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90-961

No. _____

In The

Supreme Court of the United States

October Term, 1990

ERVIN B. MADDEN,

Petitioner,

vs.

ITT LONG TERM DISABILITY PLAN FOR SALARIED EMPLOYEES; FEDERAL ELECTRIC CORPORATION,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The questions presented by this case have to do with determining the rights of beneficiaries to an ERISA disability plan.

1. Is the Ninth Circuit's rule that decisions of a third party insurance company hired to process claims of an ERISA disability plan are entitled to the arbitrary and capricious standard of review in conflict with the Eleventh Circuit and the law articulated in *Firestone Tire & Rubber Co. v. Bruch* (1989) 109 S.Ct. 948?

2. Did the Ninth Circuit err in agreeing that an ERISA disability plan had the right to recover $19,546.27 from petitioner based on payment to him of three years of retroactive Social Security Disability benefits when the Summary Plan Description did not provide for the Plan to recoup retroactive moneys, and there was no agreement concerning the subject?

LIST OF PARTIES AND RULE 28.1 LIST

Petitioner, ERVIN B. MADDEN, an individual; ITT LONG TERM DISABILITY PLAN FOR SALARIED EMPLOYEES; FEDERAL ELECTRIC CORPORATION; all are parties to the proceedings below. In addition, METROPOLITAN INSURANCE COMPANY was given ERISA fiduciary status in the decision of the Ninth Circuit Court of Appeal and is therefore mentioned.

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Petitioner, ERVIN B. MADDEN, respectfully prays that a Writ of Certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit entered in this proceeding on September 17, 1990.

OPINIONS BELOW

The opinion of the Ninth Circuit Court of Appeals is published as Madden vs. ITT Long Term Disability Plan for Salaried Employees, Federal Electric, 9th CIR Sept. 1990, 914 F.2d 1279-1287, and is contained in the slip opinion at Appendix 1 to 22. This case was presented to the Ninth Circuit on appeal of a judgment based on the granting of a motion for summary judgment entered by the trial court in the United States Federal District Court, Central District, on April 25, 1989. Judgment in the trial court is Appendix 23-24.

JURISDICTION

Petitioner seeks review of the Ninth Circuit Court of Appeal decision which was entered on September 17, 1990. Jurisdiction is invoked pursuant to Supreme Court Rule 10(a) on the ground that there is a conflict between the Ninth and Eleventh Circuit Courts of Appeal as to whether decisions of an insurance company retained to process claims of an ERISA disability plan are to be reviewed de novo or by the arbitrary and capricious standard. Also, jurisdiction is invoked pursuant to Supreme Court Rule 10(c) on the ground the Ninth Circuit decided an important question of law which has not been settled by this Court, to wit, whether an ERISA Disability Plan can obtain a money judgment against a beneficiary of the plan for retroactive funds obtained by the beneficiary from the Social Security Administration when there is no provision for same in the plan summary description. Petitioner relies on Supreme Court Rule 13.1 and 28 U.S.C. section 2101[c] which require a Petition for

Writ of Certiorari to be filed within 90 days after entry of a judgment or decree in a civil action.

The basis for subject matter jurisdiction in the Federal District Court for the Central District of California, where this case originated, is the Employee Retirement Income Security Act of 1974 (ERISA), § 502(e)(1) [U.S.C. 1132(e)], which confers jurisdiction of ERISA matters on the Federal District Courts.

STATUTES AND REGULATIONS INVOLVED

The statutes and regulations involved in this case are as follows:

> Supreme Court Rule 10(a); Supreme Court Rule 10(c); Supreme Court Rule 13.1, 28 U.S.C. § 2101[c]; Employee Retirement Income Security Act of 1974 (ERISA), § 502(e)(1) [U.S.C. 1132(e)]; ERISA Section 503; Slip opinion 11397, 29 U.S.C. § 1105(c)(a) (1988); 29 U.S.C. § 1132(a)(1)(B); 29 U.S.C. § 1132(g)(1); H.R. Rep. No. 93-533, reprinted in 1974 U.S. Code Cong. & Admin. News, 4639 (House Report), at 4655; 29 U.S.C. § 1001(b); ERISA Section 102(b); 29 U.S.C. § 1022(b); 29 C.F.R. 2520.102-3; 29 U.S.C. § 1022.

STATEMENT OF THE CASE

Petitioner, born August 26, 1946, was employed for 11 years with Federal Electric Corporation (Federal) when he sustained an injury to his spine and as a result has not worked since February 13, 1983. From 1983 to June 1, 1986, ITT Long Term Disability Plan for Salaried Employees and Employer Benefit Plan, of which petitioner was a beneficiary, paid petitioner disability benefits for long term disability.[1] On May 21, 1985, MADDEN

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[1] The disability plan consisted of two tiers:

"1. During the first year in which you receive LTD benefits, you are considered totally disabled if you are unable to

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testified at a Social Security Hearing in San Luis Obispo in furtherance of his appeal of administrative denial of benefits. In early 1986 an administrative law judge issued an award for Social Security benefits, finding the MADDEN satisfied requirements of receiving Social Security Disability commencing February 14, 1983. (CR 23, p. 61)

ITT had a provision in its Plan which authorized the delegation of the power to administer claims to an insurance company. Equitable Life Insurance Company administered the Plan until February 1986, after which Metropolitan Insurance Company was awarded the contract to administer ITT's Long Term Disability claims.

The Plan Summary Description contained a provision which pertained to "Other Disability Income Benefits."[2]

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perform the regular duties of your ITT job and are not employed elsewhere.

"2. After the first year, total disability means you are unable to engage in any occupation for which you are qualified, based on your training, education, or experience." (CR 23 pp. 36-42, Summary Plan Description.) [App. 25-26]

[2] **Other Disability Income Benefits**

Your benefit from the LTD plan may include disability benefits payable to you from any of the following sources:

* Workers' Compensation
* Social Security and the Railroad Retirement Board
* Other Plans, including disability or pension benefits any employer contributes to, or makes payroll deductions for, any employer disability income plan, or any benefits payable under any state law or similar governmental law, foreign or domestic.

Only the benefits payable from these sources on your behalf are included in your plan benefit. Benefits payable on behalf of your family members are not included. In addition, once you have begun receiving an LTD benefit, it will not be reduced by any increase in benefits you may be entitled to from other sources.

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(CR 21 p. 83) [App. 37] There is no provision in the SPD which provides that when there is a retroactive Social Security disability payment received by a beneficiary, that the beneficiary is to reimburse the Plan for Plan benefits received prior to the issuance of the Social Security award.

In early March 1986, Metropolitan was advised by Federal that MADDEN had received a Social Security Disability award. It was the policy of Metropolitan, according to deposition testimony of its claim supervisors, to ignore Social Security Disability awards except to request information that would allow Metropolitan to take credit against disability payments for moneys received by a beneficiary.

On May 1, 1986, Metropolitan wrote to MADDEN and advised him that based on medical information, he was no longer considered eligible to receive long term disability benefits (CR 23, p. 52). The letter advised MADDEN of his right to appeal and MADDEN forwarded his letter of appeal dated May 28, 1986, to Metropolitan (CR 23, p. 53). Metropolitan denied the appeal and MADDEN subsequently filed his lawsuit in the U.S. Federal District Court, Central District of California.[3]

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EXAMPLE OF A DISABILITY BENEFIT

Suppose your base monthly salary was $1,200 a month and you qualified for a Social Security disability benefit of $400 a month. Your monthly LTD benefit would be:

$1,200 times 55%	$660
Minus: Social Security payable to you (not including benefits payable to your family)	-400
Benefit from the LTD plan	$260

[3] The Ninth Circuit's third footnote indicates there was no evidence in the record pertaining to Dr. Jean Michaels'

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MADDEN contended in his complaint that he qualified for the second tier of Long Term Disability payments

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orthopedic evaluation requested by the Social Security Administration. This is incorrect, as the Social Security award and the administrative law judge's reasons for the award were part of the record and included reference to Dr. Jean Michaels' orthopedic exam, the results thereof, and Dr. Michaels' opinion that MADDEN was disabled from competing in the labor market. Also, Dr. Michaels' deposition was taken and her report was an exhibit in the deposition. Although the Ninth Circuit opinion does not deal extensively with evidentiary matters concerning MADDEN's disability, there are references which infer that MADDEN had little or no evidence to support his ongoing claim for total disability, creating a possible inference that a *de novo* review would be moot because the same result would follow. To dispel such inferences, the following are some references from MADDEN's opening brief before the Ninth Circuit concerning his disability. (Opening Brief, pp. 2-3):

> "At the time payments were terminated, MADDEN had back and leg pain and a neuropathy that resulted in numbness and weakness in his limbs, especially in the upper extremities. MADDEN had difficulty in writing more than one paragraph without stopping to rest and sometimes an arm would jerk uncontrollably (CR 23, p. 28). Whenever MADDEN walked more than a few feet, he wore a long leg brace that extended to his left hip and left knee, and most of the time he had to use a cane. He also utilized a TENS unit and took multiple types of medication. His ability to stand and walk was limited, and in March 1986 his doctor reported he could sit for 35 to 45 minutes and, with the aid of a cane, walk no more than 300 yards or sometimes as much as half a mile (CR 23, p. 28). Since than MADDEN's condition has worsened (CR 22, Declaration of MADDEN, p. 50). MADDEN had to lie down on multiple occasions during the day to get relief and at night he sleeps sporadically (CR 22, p. 4, p. 48).
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> * * *

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in accordance with the requirements of the Plan. In his second count he requested equitable relief against his

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"In May 1986, he mailed a copy of his Social Security award together with a medical report from Orthopedic Specialist Dr. Jean Michaels to Metropolitan Claims near Utica, New York (CR 22, p. 50).

* * *

(Opening Brief, pp. 6-7)

"On February 5, 1985, Dr. Smith stated that MADDEN's condition recently was worse, especially the numbness in his arms (CR 20, p. 25).

"On February 14, 1985, Judith A. Willis, M.D., of Santa Barbara Neurological Associates, wrote a six-page report. This doctor diagnosed polyneuropathy – diffuse, C8 radiculopathy left upper extremity, bilateral lumbosacral radioculopathy left greater than right, with prominent L5-S1, possibly F4 involvement, chronic pain syndome [sic] associated with depression, chronic recurrent headaches, suspect musculoskeletal. Dr. Willis concluded that MADDEN fell into the category of 'chronic pain patient, with all the attendant connotations' and recommended that MADDEN be referred to a multidisciplinary pain center for inpatient care (CR 23, pps. 19-24).

"On May 15, 1985, Dr. Smith wrote to the Social Security Administration and stated:

April 23, 1985. Throughout this period time, Mr. Madden has remained continuously disabled for gainful employment. At first the disability was due to a degenerative L5-S1 disc, for which he underwent chemonucleolysis and subsequent surgery- . . . Since that time Mr. Madden has developed a progressive peripheral neuropathy which is yet undiagnosed. . . . Symptoms consist of back and leg

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employer to reinstate certain insurance policies which provided coverage and premium waivers as long as he was eligible to receive Long Term Disability benefits.

On February 9, 1989, ITT filed a motion for summary judgment in which it contended that Metropolitan's decision to terminate MADDEN's benefits was entitled to deference and the arbitrary and capricious standard, and for this reason the evidence supported a summary judgment sustaining Metropolitan's decision to terminate MADDEN's disability benefits. ITT also moved that FEDERAL be dismissed as a party because joinder of FEDERAL was improper as FEDERAL was not a fiduciary. Later ITT filed an amended pleading in which it requested affirmative relief of reimbursement from MADDEN in the sum of $19,546.27 on the ground that MADDEN received these sums retroactively as a Social Security benefit and was required to reimburse these funds to ITT.

MADDEN contended in his opposition that the *de novo* standard was applicable, that the count against FEDERAL for equitable relief was a Pendant claim, and that ITT was not entitled to retroactive funds MADDEN received from Social Security because there was no provision in the Plan Summary Description for such reimbursement. MADDEN did not sign any agreement with ITT pertaining to the subject of reimbursing ITT in the event he received retroactive Social Security moneys. MADDEN also requested affirmative relief in a cross-motion, in which he maintained his Social Security disability award and accompanying medical support should have been

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pain, with numbness in four limbs. He has impairment of walking, sitting, and standing. There were objective findings of muscle spasm, positive nerve root stretching tests and reflex abnormalities.' (CR 23, pps. 28-30)."

utilized as evidence by Metropolitan in arriving at its decision.

The Federal District Court agreed with ITT and all of its theories and granted the motion for summary judgment. The Court noted that the recent Supreme Court case of *Firestone Tire & Rubber v. Bruch*, compelled such a finding, as the trial judge stated:

> "*Firestone Tire & Rubber v. Bruch* has set forth a *de novo* standard unless the Plan expressly give authority to the administrator or fiduciary, whatever the case may be at the time . . . " [RT p. 9 line 23 p. 10 line 10]

Further, the district judge said:

> "Here that authority is given in § 7, paragraph 6. Therefore, the more differential standard of review is proper here." (RT p. 10, lines 3-5)

Section 7, paragraph 6, is a reference to the ITT Plan itself, and it states:

> "The LTD Administrative Committee shall have the exclusive right, except as to matters which the Board of Directors from time to time may reserve to itself, to interpret the Plan and to decide any and all matters arising hereunder, including the right to remedy possible ambiguities, inequities, inconsistencies, or omissions . . . " (CR 23, p. 118)

Section 7 of the Plan is entitled "Administration of the Plan" (CR 23, p. 115). Paragraphs 5 and 8 of Section 7 give the LTD Administration Committee the right to delegate its authority.[4]

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[4] " . . . The LTF Administrative Committee may delegate its authority with respect to the denial, granting, and administration of claims to a claim administrator, which may be an insurance company or other appropriate named fiduciary and may enter into a Claims Administration Agreement with such claim administrator for the handling and determination of claims including, *but not limited to, the granting or denial of*

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The contractual agreement providing for processing of claims by Metropolitan is entitled "Administrative Services Agreement" (CR 21, pp. 87-109). [App. 46-64]

Metropolitan's claim office which processed ITT claims is located in a suburb of Utica, New York. Metropolitan's Ronda Austin, claims supervisor, testified in her deposition that Metropolitan claims had complete authority with reference to accepting or denying ITT Disability claims:

> "Q. And was it the purpose of Metropolitan Life claims to determine Mr. Madden's eligibility to receive benefits based on a summary Plan description entitled, 'Long Term Disability For You.'?
>
> "A. Yes.
>
> "Q. Now, did Metropolitan claims have complete authority with reference to accepting or denying ITT Disability claims?
>
> "A. Yes." (CR 23, p. 134, lines 6-14)

Ms. Austin's testimony is confirmed in responses to interrogatories where ITT denied knowledge of the reasons for terminating MADDEN's disability benefits and advised MADDEN to seek information by posing interrogatories to Metropolitan, to wit:

> Interrogatory 3:
>
> "What is the name, address, and title of each individual, other than the above, who participated in making the decision to deny benefits to plaintiff?"

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claims and any appeals therefrom." (CR 23, p. 117) (Emphasis added)

"Provided that the LTD Administration Committee may, in its discretion, also enter into any type of contract with any insurance company or companies selected by it for providing benefits under the plan." (CR 23, p. 121)

Response to Interrogatory 3:

"The decision with respect to plaintiff's claim was made by Metropolitan Life Insurance Company, not defendant, and the Interrogatory should be served on Metropolitan . . . " (CR 22, p. 18, lines 21-27)

The Administrative Services Agreement (the Agreement) states in part as follows:

"Metropolitan will have fiduciary responsibility for provision of full and fair review of claim denials pursuant to Section 503 of ERISA." (CR 21, p. 94) [App. 52] [including purpose clause App. 47]

Also:

"In the administration of claims under this Agreement, Metropolitan will follow the claims standards developed by Metropolitan for processing of Long Term Disability claims in connection with its administrative services business unless other interpretation is to be applied pursuant to the following paragraph.

"The Determination of the extent of the benefits to which any claimant is entitled under the Plan shall initially rest with Metropolitan. However, in the event that ITT determines that Metropolitan has misinterpreted the Plan and so informs Metropolitan in writing of the appropriate interpretation and such interpretation is deemed not unreasonable and not inconsistent with the terms of the Plan to Metropolitan, all claims processed after delivery of such writing to Metropolitan shall be administered in accordance with the interpretation of ITT, set forth in such writing." (CR 21, 95-96) [App. 53]

Further, the Agreement specifies that:

"1. It is mutually recognized that Metropolitan, in performing its obligation under this Agreement, is acting only as an agent of ITT and shall not be designated or deemed the administrator with respect to the Plan for the purposes of ERISA or any other Federal or state law or

> regulation of similar nature with the exception of its duties as the appropriate named fiduciary for review of claim denials under the Plan." (CR 21, p. 105) [App. 60]

Per terms of the Agreement between ITT and Metropolitan, Metropolitan was to receive "$98 per new claim approval . . . $160 per outstanding claim at the end of the Experience Period . . . $52,000 to cover all other services outside the claim activity including secretarial services and the fiduciary for appeal of denied claims. In addition fees were to include $50 per hour for loading the existing claim files onto Metropolitan's claim adjudication system . . . $50 per hour for reviewing existing claim files for continued disability status, Social Security eligibility, and rehabilitation potential . . . " (CR 21 100). [App. 56]

MADDEN stated in his opening brief to the Ninth Circuit that it was not the Plan fiduciary who made the decision to terminate his Long Term Disability benefits, but Metropolitan's claims department, and contended Metropolitan's decision should not be deserving of deference and the standard of arbitrary and capricious review. MADDEN argued that although ERISA allows the delegation of fiduciary authority, based on the case of *Firestone Tire & Rubber Co. v. Bruch, supra* and the facts of this case, it was not proper to allow the decisions of the claims department personnel to be subject to review under the arbitrary and capricious standard. In this regard, MADDEN pointed out that Metropolitan was not given authorization by the Plan to decide claims, nor was the Metropolitan claims department a fiduciary, and for these reasons, based on *Firestone*, Metropolitan's decision to terminate MADDEN's disability benefits does not have the attributes of deference and the arbitrary and capricious standard of review. MADDEN reiterated in his opposition to the motion for summary judgment and his opening brief to the Ninth circuit, as well as in oral argument, that his case should be reviewed *de novo*.

The Ninth Circuit Court of Appeals did not agree with MADDEN that the Motion for Summary Judgment should be reviewed *de novo* and stated:

> "Because the Plan gives the LTD Administration Committee discretionary authority and the Committee has properly designated Metropolitan as ERISA fiduciary, we review Metropolitan's decision to terminate MADDEN's Plan benefits under the more deferential 'arbitrary and capricious' standard. See *Firestone*, 109 S.Ct. at 956; ERISA, 29 U.S.C. § 1105(c)(1) (1988)." (Madden v. ITT Long Term Disability Plan for Salaried Employees; Federal Electric Corporation. [9th Cir. Sept. 1990, 914 F.2d 1279-1287, slip opinion 11397, App. 14-15]

The Ninth Circuit's finding was:

> "[2] In accordance with the logic and reasoning of *Firestone*, we hold that where (1) the ERISA plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan and (2) pursuant to ERISA, 29 U.S.C. § 1105(c)(a) (1988), a named fiduciary properly designates another fiduciary, delegating its discretionary authority, the "arbitrary and capricious" standard of review for ERISA claims brought under § 1132(a)(1)(B) applies to the designated ERISA fiduciary as well as to the named fiduciary. *Accord Bali v. Blue Cross & Shield Ass'n*, 873 F.2d 1043, 1047 (7th Cir. 1989) (where the plan gives administrator discretionary authority regarding document requests and insurer acts as plan administrator, discretionary standard of review applied to insurer's document requests); *see Firestone*, 109 S. Ct. at 956; *see also Filary v. General Am. Life Ins. Co.*, 711 F.Supp. 528, 530 (D. Ariz. 1989) (insurer's benefit claim denial, based on discretionary authority to construe plan, reviewed under arbitrary and capricious standard)." *Madden v. ITT Long Term Disability Plan, supra;* slip opinion 11394, App. 12]

(In accordance with 29 U.S.C. § 1132(g)(1), MADDEN has requested attorney fees from the beginning of this case and likewise does so at this juncture.)

The facts in the Eleventh Circuit case of *Baker v. Big Star Division of the Grand Union Company* (11th Cir. 1989) 893 F.2d 288, have striking similarities to the facts of MADDEN's case. Mr. Baker was an employee of Grand Union for 13 years and left work in October 1983 due to a back condition. He was the beneficiary of a two-tier disability plan which provided benefits for two years in the event he could not perform the duties of his regular occupation, and for additional periods if he were unable to perform any occupation for which he was qualified. *Baker v. Big Star Division of the Grand Union Company, supra,* 893 F.2d 288, 289.

Connecticut General Life Insurance Company, who was retained by the Plan to administer claims, arranged for Mr. Baker to be examined by one of its own consultants and thereafter terminated Baker's disability payments on the ground that he did not qualify under the total disability clause. Baker filed a lawsuit in the state court and it was removed to the District Court for the Northern District of Georgia, where the defendant Plan filed a motion for summary judgment. At the time the *Baker* case was litigated in the District Court, *Firestone Tire & Rubber Co. v. Bruch* had not been published. The District Court found that Connecticut General was not a proper party because it was not a fiduciary and could not be held liable under ERISA. It also ruled that Connecticut's decision to terminate Baker's disability was to be reviewed by the arbitrary and capricious standard and thus affirmed Connecticut's denial of benefits. Baker thereafter appealed to the Eleventh Circuit.

The Eleventh Circuit, in reliance on the newly published *Firestone Tire & Rubber Co. v. Bruch,* endorsed the district judge's finding that Connecticut was not a fiduciary but found that Connecticut General's decision was not entitled to deference and the arbitrary and capricious standard, and that Baker should have had his case

reviewed *de novo* by the District Court. In this regard, the Eleventh Circuit called attention to the agreement between the Plan and Connecticut General entitled, "Administrative Service Agreement" and stated:

> "Connecticut General processed claims and disbursed benefit payments pursuant to Plan terms under an administrative services agreement with Grand Union . . . Grand Union did no more than 'rent' the claims processing department of Connecticut General to review claims and determine the amount payable 'in accordance with the terms and conditions of the plan' . . . An insurance company does not become an ERISA 'fiduciary' simply by performing administrative functions and claims processing within a framework of rules established by an employer . . . " *Baker, supra,* 290.

In finding that Connecticut's decision was not entitled to deference and the arbitrary and capricious standard, the Eleventh Circuit, in reliance on the opinion in *Firestone Tire & Rubber Co. v. Bruch,* stated:

> "Any entity or person found not to be an ERISA 'fiduciary' cannot be an 'administrator' with discretionary authority 'subject to the arbitrary and capricious standard.' " *Baker, supra,* p.291

Grand Union argued that as a Plan fiduciary, it had an inherit discretionary authority which it delegated to Connecticut General and that therefore Connecticut General's decision should be subject to the arbitrary and capricious standard. The Eleventh Circuit denied such logic satisfied the test of *Firestone Tire & Rubber Co. v. Bruch* for application of an arbitrary and capricious standard of review. The Eleventh Circuit noted:

> "Grand Union, not Connecticut General, was given the authority to review claim denials; nor was Connecticut General given the power to formulate policy or terms of eligibility under the Plan." *Baker, supra,* pp.291-292.

Another post *Firestone* case which appears to be inconsistent with the ruling of the Ninth Circuit in your

petitioner's case is the Seventh Circuit case of *Betty L. Bucholz v. The General Electric Employee Benefit Plan* (N.D. Ill., W.D., Aug. 22, 1989), 720 F.Supp. 102. This Seventh District Court stated it was also relying on *Firestone Tire & Rubber Co. v. Bruch, supra,* and opined that although the Plan gave Travelers Insurance Company the function and responsibility of claims handling, in the context of the Plan there was not included "a proclamation of final or discretionary authority," and since the test of *Firestone* mandated that a Plan must specifically provide for discretionary authority to a fiduciary in order to avoid the *de novo* standard of review, denied the Plan's argument that Traveler's decision was subject to the arbitrary and capricious standard. *Bucholz v. General Electric Employee Benefit Plan, supra,* 720 F.Supp. 102, 103.

REASONS FOR GRANTING THE WRIT

1. THE CONCEPT OF ERISA THAT FAIRNESS AND STABILITY WILL RESULT FROM UNIFORM REGULATION OF EMPLOYER BENEFIT PLANS IS THREATENED BY CONFLICTING DECISIONS OF THE NINTH AND ELEVENTH CIRCUITS.

The Ninth and Eleventh Circuit Courts of Appeals when faced with the same important issue of ERISA law and similar facts, relied on the recent Supreme Court case of *Firestone Tire & Rubber Co, et al. v. Bruch,* (1989) but interpreted the *Firestone* case differently and came to inconsistent, if not contradictory, conclusions.

SIMILARITY OF FACTS

The controversy in your petitioner's Ninth Circuit case and in the Eleventh Circuit case of *Baker v. Big Star Division of the Grand Union Company, supra,* originated when beneficiaries of an ERISA's long-term disability plan sought to reverse the denial of benefits by an insurance company which was retained to administer claims of the ERISA disability plan.

In each instance, the disability plan had a two-tier system of payments: Firstly, a beneficiary was entitled to receive payments for two years if he or she was disabled from performing regular work; secondly, in order to be eligible to receive disability payments, the disability must be such where a beneficiary is unable to work at any gainful occupation he or she is capable of performing.

In each case after denial of the second tier benefit by the insurance company, the beneficiaries sought relief by filing a lawsuit in their respective Federal District Courts, where motions for summary judgment were filed by the defendant Plans. Both Plans contended in their motions for summary judgment that the District Court should be guided by the arbitrary and capricious standard of review, and that the insurance company's decision was entitled to deference. The beneficiary plaintiffs requested a *de novo* review by the District Courts. In each case the District Court ruled that the *de novo* standard was not applicable, the arbitrary and capricious standard was proper, and motions for summary judgment were granted.

Each plaintiff beneficiary appealed to their respective Court of Appeals, contending that the District Court erred in granting the insurance company's decision, deference, and protection by the arbitrary and capricious standard of review.

THE SAME LAW BUT OPPOSITE RESULTS

At this point the parallel or similarity of events came to a halt. The Ninth Circuit Court of Appeals found that based on the case of *Firestone Tire & Rubber Co. v. Bruch, supra,* the District Court's decision was affirmed. In this regard the Ninth Circuit ruled that when ITT delegated power to Metropolitan Insurance Company to administer claims, such delegation was to a fiduciary and carried with it the right to have Metropolitan's decisions protected by the concept of deference and the arbitrary and capricious standard.

The Eleventh Circuit Court of Appeals in *Baker v. Big Star Division of the Grand Union Company, supra,* based on the same Supreme Court case (*Firestone*) reversed its District Court and ruled that when an insurance company has been delegated an administrative function to decide claims, that the insurance company is not a fiduciary, and such insurance company's decisions are subject to a *de novo* hearing if a lawsuit objecting to the insurance company's decisions is filed in the District Court. Since both Appellate Courts based their opinions on the interpretation of the *Firestone Tire & Rubber Co.* case, it is respectfully submitted that there is a conflict which requires resolution by the Supreme Court.

THE NECESSITY FOR CERTIORARI

Both Courts of Appeals opinions are published. Thus, each case may be used by ERISA litigants to support or attack the denial or granting of benefits by an insurance carrier who is designated by a plan to administer benefits.

The large number of beneficiaries who present claims for ERISA benefits comprise a significant portion of our population that will be affected economically and socially, depending on whether the Ninth circuit or the Eleventh Circuit opinion is applicable.

It is plain that if certiorari is not granted, the dichotomy between the Ninth and Eleventh Circuits with respect to the issue of whether beneficiaries have a right to a *de novo* review will persist, and that the beneficiaries in the Eleventh Circuit will have an advantage not shared with the beneficiaries in the jurisdiction covered by the Ninth Circuit. This is a result which is not in keeping with the purpose of ERISA. The intent of Congress was " . . . to provide to a uniform source of law in the areas of vesting, funding, insurance, and portability standards . . . " *H.R. Rep. No. 93-533, reprinted in 1974 U.S. Code Cong. & Admin. News, 4639 (House Report), at 4655.* To

insure uniformity, state law was specifically preempted, *id. 4655.*

It is necessary that a hearing be granted to resolve the inconsistent interpretations of law so that the principals of uniformity of decision concerning ERISA may be preserved. A hearing is also necessary to dispel confusion about which of the circuit opinions should be followed and to clarify the matter for millions of beneficiaries who are subject to administerial decision-making by insurance companies hired by ERISA benefit plans.

2. THE NINTH CIRCUIT'S INTERPRETATION OF *FIRESTONE* SHOULD BE REJECTED AND THE ELEVENTH CIRCUIT'S ACCEPTED BECAUSE THE NINTH CIRCUIT'S RATIONALE AND CONCLUSION ARE INCONSISTENT WITH THE SUPREME COURT'S GUIDELINES AND RULING IN *FIRESTONE*, AND THE ELEVENTH CIRCUIT'S POSITION IS CONSISTENT WITH *FIRESTONE*.

In his opening brief, MADDEN urged two related reasons in support of his position that he was deserving of a *de novo* hearing. Primary to both was the admission that ITT, the named fiduciary, and the LTD Committee who were given authority by the Plan to administer the long-term disability benefits, did not participate in the decision to curtail petitioner's disability payments.[5]

Petitioner's reasons for reversal of the District Court were:

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[5] As noted earlier, a written agreement between ITT and Metropolitan provided for the latter to administer all aspects of LTD claims. The complete absence of decision-making by ITT and the LTD Committee is underscored by a Metropolitan supervisor's deposition testimony confirming Metropolitan was the sole decision maker, and by ITT's response to interrogatories, wherein it stated it had nothing to do with the decision-making and inquiries should be made of Metropolitan.

1. The decision of Metropolitan's claims department to terminate MADDEN's payments was made by a nonfiduciary and the essence of *Firestone Tire & Rubber Co.* is against allowing a nonfiduciary decision, deference, and the arbitrary and capricious standard.[6]

2. The Supreme Court in *Firestone* mandated that in order for deference and the arbitrary and capricious standard to be predicated of a fiduciary's decision, the Plan must provide the fiduciary with a specific power or authorization to make the decision.[7]

Contrary to the Ninth Circuit's opinion, Metropolitan was not a fiduciary in its claim function capacity.

Federal courts, including the Ninth Circuit, have decided that an insurance company's function in

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[6] Opening Brief, p. 11: It was MADDEN's position that although the law allows the delegation of fiduciary authority under ERISA, based on the case of *Firestone Tire & Rubber Co. v. Bruch, supra,* it is not correct to make an inferential leap and say that since a fiduciary is bound by the decision of its delegatee, the delegatee must be given the same deference and be subject to review under the standard of arbitrary and capricious as if the decision was (originally) made by the Plan fiduciary.

[7] Opening Brief Page 16: "An explanation of the above in the context of *Firestone* is in order. The Court's holding in *Firestone* reads as follows:

> " 'Consistent with the established principles of trust law, we hold that a denial of benefits challenged under ¶ 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit Plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.' (*Firestone, ibid.*, pp.948, 956)

A key phrase is 'gives the administrator or fiduciary discretionary authority to determine eligibility.' In this instance, although ITT was given authority, it delegated away its authority, . . . "

administering claims under an ERISA benefit plan cannot be a basis for suing the insurance company in an ERISA action because the insurance company is not a fiduciary. *Gelardi v. Pertec Computer Core*, 761 F.2d 1323, 1324-25 (9th Cir. 1985); *Gibson v. The Prudential Insurance Co.*, (9th Cir. Oct. 1990) 915 F.2d 414; *Baker v. Big Star Division of the Grand Union Company, supra.*

A review of the pertinent paragraphs in the Claims Administration Agreement discloses that when Metropolitan made its decision to terminate MADDEN's payments it was acting purely as a claims administrator, and that it was paid as such by the Plan. The Ninth Circuit's footnote on page 11396 of its Slip Opinion to the effect that "The Claims Administration Agreement expressly provides that Metropolitan has fiduciary responsibility" refers to the provision in the Agreement which states: "Metropolitan will have fiduciary responsibility for provision of full and fair review of claim denials." This statement specifically alludes to "fiduciary responsibility for provision of full and fair review of claim denials," as opposed to Metropolitan's claims processing, which is addressed in another part of the Agreement.

The intent of parties to the Claims Administration Agreement as to whether Metropolitan was to be a fiduciary in processing claims was addressed in the Agreement, which made it clear that Metropolitan's function of processing, granting, and denying claims was not to be in the capacity of a fiduciary.[8]

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[8] This brief, page 9. Because of its importance, the statement from the Agreement is quoted here: "It is mutually recognized that Metropolitan, in performing its obligation under this Agreement, is acting only as an agent of ITT and should not be designated or deemed the administrator with respect to the Plan for the purposes of ERISA or any other Federal or State law or regulation of similar nature, with the exceptions of its duties as the appropriate named fiduciary for review of claim denials under the Plan." [App. 60]

There can be no doubt Metropolitan's decision to terminate his benefits was a claims processing decision. The Ninth Circuit infers that the assignment of the fiduciary responsibility to Metropolitan for reviewing Appeals included fiduciary responsibility for processing claims, but the latter inference is incorrect based on the Administrative Service Agreement (fn 8).

It is respectfully submitted that the decision of terminating MADDEN's benefits was made by an insurance carrier claims department which, at the time, was not a fiduciary. In accordance with *Gelardi v. Pertec Computer Core, supra, Gibson v. The Prudential Insurance Co. supra,* and *Baker v. Big Star Division of the Grand Union Company, supra,* an insurance company who merely processes or administers claims is not a fiduciary.

The Ninth Circuit Court of Appeals did not properly interpret Firestone v. Bruch, supra.

Based on *Firestone Tire & Rubber Co. v. Bruch,* the test for properly invoking the concepts of deference and arbitrary and capricious standard is not whether the decision maker is a Plan fiduciary, but whether the decision is made by a Plan fiduciary who, by the Plan, is given specific authority or power to make the decision in question. This proposition follows from Justice O'Connor's statement that, "We hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under the *de novo* standard unless the Benefit Plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the Plan." (*Firestone, ibid.,* 956.) This proposition is underscored when considering that in *Firestone* a named fiduciary was not allowed to take advantage of the arbitrary and capricious standard because there was a failure in the Plan to specifically provide the fiduciary with the power to make the decision.

In this instance, ITT was given authority by the Plan, as was the LTD Committee, to make claims level decisions. But, this granted power was not utilized by the

Plan fiduciaries. The application of deference and the arbitrary and capricious standard when fiduciaries are given power to make decisions and do not exercise the power but delegate same to a nonfiduciary administerial entity was not directly raised by the *Firestone* Court. However, this issue was faced by the Eleventh Circuit in the case of *Baker v. Big Star Division of the Grand Union Company, supra,* who denied that under such facts an insurance company's administerial claims decisions were protected by the concept of deference and the arbitrary and capricious standard. In this regard, the Court, in *Baker* stated:

> "Grand Union, not Connecticut General, was given the authority to review claim denials; nor was Connecticut General given the power to formulate policy or terms of eligibility under the Plan." *Baker, supra,* 291-292.

The argument that discretionary authority existed in the Plan fiduciary and that this was sufficient to support the differential standard of judicial review when the actual decision was made by an insurance company was rejected by the Eleventh Circuit in *Baker, id.* at 291. Reference is made to the additional Eleventh Circuit case of *Moon v. American Home & Assurance Co.*, 888 F.2d 86 (11th Cir. 1989), where the *de novo* standard of review was applied because the denial of benefits was made by an insurance company and not the administrator of the Plan.

A District Court in the Seventh Circuit has sided with the interpretation of *Firestone* offered by the Eleventh Circuit. In *Bucholz v. The General Electric Employee Benefits Plan and The Travelers Insurance Company,* (1989) 720 F.Supp. 102, the District Court for the Northern District of Illinois analyzed *Firestone* to determine whether the denial of benefits by Travelers in a wrongful death action under an ERISA benefit plan was entitled to deference and the arbitrary and capricious standard. This District Court accepted the rationale of *Firestone* (contrary to the District Court in your petitioner's case) to the effect that according to *Firestone,* a *de novo* standard of review

should be utilized by a District Court in reviewing a decision to deny ERISA benefits unless there is present an exception which allows deference and the arbitrary and capricious standard to apply to the decision. The exception referred to by the Seventh Circuit Court is articulated by a quotation from *Firestone,* to wit:

> "Unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or construe the terms of the plan." *Firestone, id.,* 956. *Bucholz v. The General Electric Employee Benefits Plan, supra,* 103.

In holding that Traveler's decision was not entitled to deference, the Illinois District Court stated "the Firestone court contemplated, in proclaiming its exception, Plan provisions that clearly and expressly provide an administrator the final say" *Bucholz, id.* 104.

Thus, not only does the Eleventh Circuit interpret *Firestone* to mean that it is necessary that the Plan specifically give authority to the decision maker in order for the decision to have deference and be protected by the arbitrary and capricious standard, but so does the Seventh Circuit. The Ninth Circuit obviously does not agree with such interpretation of *Firestone,* as the Ninth Circuit opined that although Metropolitan, was not mentioned in the Plan, its decisions are subject to the differential and arbitrary and capricious standard. The Ninth Circuit is out of step with the Eleventh and Seventh Circuits and, therefore, it is respectfully suggested that relief be granted to petitioner in the quest for uniformity of ERISA.

3. THE NINTH CIRCUIT RULING WHICH PROVIDES THAT ITT IS ENTITLED TO REIMBURSEMENT FROM RETROACTIVE SOCIAL SECURITY PAYMENTS IS ERRONEOUS BECAUSE THE SPD DOES NOT MENTION OR REFER TO THE RIGHT OF THE PLAN TO RECEIVE RETROACTIVE SOCIAL SECURITY PAYMENTS.

This Court has noted in the past that ERISA is a "comprehensive and reticulated statute" formulated with

specific rules by Congress aimed at enhancing "the well-being and security of millions of employees and their dependents," *Nachman Corp. v. Pension Benefit Guarantee Corp.*, 44 U.S. 339, 361 (1980), and that "We are reluctant to 'fine-tune' an enforcement scheme crafted with such evidence care as the one in ERISA." (*Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 [1985].)

In 29 U.S.C. § 1001(b), Congress sets forth that it is a policy of the Employee Retirement Income Security Act to protect beneficiary participants by "requiring the disclosure and reporting to participants and beneficiaries . . . of information with respect . . . (to the Act, and) by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans . . . "

The Summary Plan Description is selected as the vehicle to provide the participant beneficiaries with as complete knowledge as possible, as well as information necessary to carry out the stated policy. With this concept in mind, Congress enacted Section 102(b) which, in part, states:

> "The plan description and summary plan description shall contain the following information: . . . The plan's requirements, respecting eligibility for participation and benefits; . . . circumstances which may result in disqualification, ineligibility, or denial or loss of benefits . . . " Also, contained in 29 U.S.C. § 1022(b)

The Department of Labor emphasizes the necessity for the content of the summary plan description to provide notice and disclose the reasons for disqualification or denial of benefits. In this regard, 29 C.F.R. 2520.102-3 provides:

> "Section 102 of the Act specifies information that must be included in the summary plan description; the following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated as otherwise in paragraph (j) through (n):

> "(1) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss forfeiture or suspension of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraph (j) and (k) of this section."

In the District Court case of *Zittrouer v. Uarco, Inc. Group Plan*, 582 F.Supp. 1471 (1984) (Georgia), the defendant argued that an age restriction for hospital benefits in its Plan overruled the SPD which did not contain the age restriction. The court held to the contrary as it stated:

> "This focus misses the point. By law defendant is required to include within the summary plan 'circumstances which may result in disqualification, ineligibility, or denial or loss of benefits. . . . ' 29 U.S.C. § 1022(b). Defendant's failure to do so is at best gross negligence and at worst intentional deception through concealment or inaction. The fact that defendant's summary plan included the quoted disclaimer does not relieve defendant of the statutory requirement of disclosure." *Zittrouer, supra*, 582 F.Supp. 1475 (1984)

Going outside the SPD to formulate rules concerning "denial or loss of benefits" to ERISA beneficiaries, has not been allowed by case law. *McKnight v. Southern Life & Health Insurance Co., and Southern Life & Health Insurance Co. Revised Retirement Plan*, 758 F.2d 1566 (1985).

> "ERISA provides that the summary shall be an accurate, comprehensive document that reasonable apprises the employees of their rights under the Plan." *McKnight, supra*, 758 F.2d 1570.

Further,

> "Where the trustees impose a standard not required by the pension plan itself, this court has stated that such action 'would result in an unwarranted and an arbitrary construction of

the plan.' " *Maness v. Williams*, 513 F.2d 1264, 1267 (8th Cir. 1975).

In *Wilken v. AT&T Technologies, Inc.*, (E.D. Missouri, 1984), 632 F.Supp. 772, 774, the court noted:

> "Trustees act arbitrarily when they impose a standard not required by the pension plan itself."

Since the SPD in this instance did not provide for payment of retroactive Social Security Disability benefits to the Plan, it is respectfully submitted MADDEN should not have any obligation to reimburse the Plan from three years of retroactive Social Security Disability benefits.

The Ninth Circuit cites the case of *Stewart v. Metropolitan Life Insurance Co.*, 664 F.Supp. 619, (D.ME. 1987) as authority for its ruling. However, the *Stewart* case is based on facts and law which are absent in MADDEN's case. Firstly, the plaintiffs in the *Stewart* case signed a "reimbursement agreement" in which they agreed to reimburse Metropolitan in full upon receipt of retroactive Social Security payments. *Stewart v. Metropolitan Life Insurance Co., supra*, 621. The *Stewart* Court relied in great measure on the obligation of the parties under the agreement, to wit:

> "Because the court finds Metropolitan's interpretation of the contract language to be correct as a matter of law, it follows that Metropolitan's recoupment of benefits consistent with that interpretation was not arbitrary or capricious." *Stewart, supra*, 624.

More importantly, in *Stewart* the party who requested and obtained reimbursement was Metropolitan Life Insurance Co., not the Plan administrator. This is especially significant in regard to MADDEN's case, as the court in *Stewart* noted the contention that Metropolitan violated 29 U.S.C. § 1022 (which imposes summary plan description obligations on the Plan administrator) was not applicable to Metropolitan because Metropolitan was not the Plan administrator. However, in your petitioner's case, the Plan itself is the party who is requesting reimbursement. There is no reason (as there was in the *Stewart*

case) not to apply § 1022 to ITT. In this regard, MADDEN respectfully submits that ITT is bound by § 1022, as well as the other pronouncements and case law pertaining to notice and disclosure of Summary Plan Descriptions. The Ninth Circuit failed to consider this facet of the *Stewart* case when citing it as authority for its ruling. *Stewart, supra,* 621, 622.

An inference of the *Stewart* case is that since § 1022 applies to a Plan administrator, in the event a Plan administrator attempts to obtain reimbursement of retroactive payments when the SPD did not provide for such a right, such request should be denied. In brief, ITT is not entitled to reimbursement from MADDEN's retroactive Social Security payments because the SPD does not provide ITT with a right to these monies.

CONCLUSION

The Ninth and Eleventh Circuits differ in the important matter of what the Supreme Court mandated in *Firestone Tire & Rubber Co. v. Bruch* pertaining to the standard of review to be utilized by the lower courts in ERISA Benefit Plan cases.

Whereas the Eleventh Circuit insists that based on *Firestone* in order to invoke the arbitrary and capricious standard, it is necessary that the decision to deny or award benefits be made by a party who is specifically given authorization in the Plan to make such decision, the Ninth Circuit opines it is not required that the party making the decision be given authority by the Plan if such party is delegated the authority by a fiduciary who is granted power by the Plan to make such decisions.

When analyzing the argument of *Firestone,* the Supreme Court noted:

> "Adopting *Firestone's* reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." (*Firestone Tire & Rubber Co. v. Bruch, supra,* p. 956)

If the guidelines of the Supreme Court in *Firestone* are satisfied by giving a named fiduciary the authority to make a decision and allowing the fiduciary to delegate the decision-making power to a third party insurance carrier, the beneficiaries are in a worse position than they were before the enactment of ERISA. Whereas before ERISA beneficiaries could sue an insurance company in a state court and have a de novo trial of the insurance carrier's denial of benefits with the burden of proof based on the preponderance of the evidence, under ERISA (if the Ninth Circuit is correct) relief from a decision of an insurance company hired by a Plan requires filing a lawsuit in the federal court subject to an arbitrary and capricious standard of review.

Neither should respondents attempt to portray their position as one that is distinguished by Metropolitan being a fiduciary as opposed to having its claims services "rented". The Agreement between ITT and Metropolitan specifically allocates a fiduciary status to Metropolitan as regards appeals of claim denials only. This is confirmed by the purpose clause of the Agreement (App. 47) and specific statements in the Agreement (App. 52). That Metropolitan's claims processing was strictly ministerial and not carried out in a fiduciary capacity is spelled out in the Agreement at various places but most directly in App. 60 previously quoted.

A similar comparison exists concerning the rights of beneficiaries to a de novo trial as regards Madden's grievance on the money judgment allowed the Plan. Before ERISA the rights of the parties to a disability insurance policy were governed by the terms of the insurance contract. ERISA appears to have language which requires the rights and obligations of beneficiaries to be spelled out in the Plan Summary Description (29 U.S.A.

102(B)). The SPD is usually the only document a beneficiary receives as a participant in an ERISA Benefit Plan.

If ITT is allowed to retain the money judgment against Madden, Madden has a lesser right than he would have had if he were contesting a similar issue against an insurance company in a state court. In a state court, Madden's right would be controlled by the terms of the insurance contract. If the insurance policy did not provide the insurer with the right to recoup retroactive (social security) payments, Madden would prevail. In this instance since the SPD did not give ITT a right of recoupment of retroactive social security benefits, based on 102(b) Madden should prevail.

Respectfully submitted,
LAW OFFICES OF STEVEN ROSEMAN
By
STEVEN ROSEMAN
Attorneys for Ervin B. Madden

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ERVIN B. MADDEN, *Plaintiff-Appellant,* v. ITT LONG TERM DISABILITY PLAN FOR SALARIED EMPLOYEES; FEDERAL ELECTRIC CORPORATION, *Defendants-Appellees.*	No. 89-55505 D.C. No. CV-88-2280-FFF OPINION

Appeal from the United States District Court for the Central District of California Ferdinand F. Fernandez, District Judge, Presiding

Argued and Submitted
June 6, 1990 – Pasadena, California

Filed September 17, 1990

Before: Arthur L. Alarcon, Melvin Brunetti and Diarmuid F. O'Scannlain, Circuit Judges.

Opinion by Judge Brunetti

SUMMARY

ERISA

Affirming a judgment, the court held that the arbitrary and capricious standard of review for ERISA claims brought under 29 U.S.C. § 1132(a)(1)(B) (challenge to denial of benefits) applied to a designated ERISA-fiduciary as well as to the originally-named fiduciary.

Appellant Ervin Madden was employed by appellee Federal Electric Corporation and was covered by Federal's disability plan, the appellee ITT Long Term Disability Plan for Salaried Employees. By the Plan's terms, ITT was named as Plan administrator and fiduciary, and ITT had full discretion to appoint another person to act as fiduciary/administrator in ITT's place. (Initially, ITT delegated that authority to The Equitable Life Assurance Society of the United States.) The Plan provided that eligibility during the first year of benefits merely required proof that the disabled employee was not able to perform his job and was not employed elsewhere. After the first year, however, a benefits recipient had to show he was physically unable to engage in *any* occupation for which he was otherwise qualified.

In 1983 Madden suffered an injury which left him unable to work. His doctor, Edward Smith, informed Equitable that Madden met both disability definitions, and Madden received Plan benefits for approximtely [sic] two years. Then, Smith informed Equitable that, although Madden was still unable to return to his former job, he was not totally disabled from any other occupation.

Meanwhile, Madden began receiving social security disability benefits, including a retroactive award. Madden so informed Metropolitan Life Insurance Co., which recently had replaced Equitable as ITT's delegated administrator.

Metropolitan informed Madden he appeared to be no longer qualified for Plan benefits, explained the review procedure, and invited him to submit further information. Madden requested a review, and Metropolitan

sought and received further findings from Smith. Based on those findings, Metropolitan affirmed its earlier decision. Madden filed a complaint with the state's insurance commissioner, and Metropolitan made a second review, again reaching the same conclusion. Then, in response to another review request from Madden, Metropolitan obtained a vocational assessment by an outside agency, which determined that Madden could perform other work. Prior to each review Metropolitan requested, but did not receive, further medical information from Madden.

Madden brought an ERISA suit (§ 1132(a)(1)(B)) against Federal and the Plan to recover his benefits. The Court granted summary judgment. Applying the arbitrary and capricious standard of review, the court upheld Metropolitan's decision and further determined that the Plan was entitled to social security payments Madden received while he received Plan benefits.

[1] Madden contended Metropolitan's decision to terminate benefits should have been reviewed under a de novo standard. However, [2] where an ERISA plan expressly gives an administrator or fiduciary discretionary authority to determine benefits eligibility and the named fiduciary properly delegates that authority to another fiduciary, the arbitrary and capricious standard for claims brought under § 1132(a)(1)(B) applies to the designated fiduciary as well as to the named fiduciary. [3] Metropolitan's decision to terminate Madden's benefits was not arbitrary or capricious and was supported by substantial evidence.

[4] Because the Plan's summary description provided for the reduction of Plan benefits by social security disability awards, the Plan was entitled to the retroactive benefits Madden received for the period he also received Plan benefits.

COUNSEL

Steven Roseman, Long Beach, California, for the plaintiff-appellant.

John L. Viola, Adams, Duque & Hazeltine, Los Angeles, California, for the defendants-appellees.

OPINION

BRUNETTI, Circuit Judge:

Ervin Madden ("Madden") filed suit against his employer, Federal Electric Corp. ("Federal"), and its long-term disability plan, ITT Long Term Disability Plan for Salaried Employees ("the Plan"), pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.SC. § 1132(a)(1)(B), to recover benefits allegedly due him under the terms of the Plan, arising out of the termination of Madden's long-term Plan disability benefits by Metropolitan Life Insurance Co. ("Metropolitan"), ITT's delegate, and seeking contractual damages, injunctive relief, and attorney's fees.

A. *Factual and Procedural Background*

Madden was employed by Federal for nine years as a management employee. He was extensive education and

experience in communications and electronics, including supervisory positions. On February 13, 1983 Madden suffered a spinal injury that resulted in his inability to return to work at Federal. Because of this injury, Madden applied for long-term disability benefits from the Plan.

The Plan provides two standards of disability qualifications:

> 1. During the first year in which you receive LTD (Long Term Disability) benefits you are considered totally disabled if you are unable to perform the regular duties of your ITT job and are not employed elsewhere.
>
> 2. After the first year, total disability means you are unable to engage in *any* occupation for which you are qualified, based on your training, education, or experience.

(emphasis in original).

From the period September 1983 through August 1985, Madden's own chosen physician, Dr. Edward A. Smith, a board certified neurosurgeon, periodically informed The Equitable Life Assurance Society of the United States ("Equitable"), to whom ITT had delegated its authority to administer the Plan, that Madden was disabled under both definitions of total disability. Accordingly, Madden received Plan benefits for that period.

In August 1985 Dr. Smith informed Equitable that although Madden was still totally disabled from this regular work, he was not totally disabled from any other occupation. In November 1985 Dr. Smith again indicated that Madden was not totally disabled from work, other than his own former job at Federal. Dr. Smith believed

that Madden should be able to do "semi-sedentary work," if the job allowed him to stand up after every thirty minutes of sitting and did not require lifting objects in excess of ten pounds.[1] However, Madden continued to receive Plan benefits.

Meanwhile, in October 1985 the Social Security Administration, reversing its earlier position, found that Madden had satisfied its requirements for receiving social security disability benefits commencing February 14, 1983 and awarded him retroactive benefits. On March 20, 1986 Madden phoned Metropolitan, who had replaced Equitable as ITT's delegate on January 1, 1986, and reported this retroactive benefit award.

In April 1986 Metropolitan reviewed Madden's file and determined, based on Dr. Smith's previous medical findings, the only current medical information on file, and Madden's training, education, and experience, that Madden was no longer totally disabled as defined by the Plan. Metropolitan thus informed him of the termination of his Plan benefits effective June 1, 1986. Metropolitan also explained the review procedure for such denials of benefit claims: "When requesting a review, please state the reason you believe the claim was improperly denied, and submit any data, questions or comments you deem appropriate."

Madden requested that Metropolitan review its decision to terminate his benefits, alleging that Dr. Smith had

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[1] His former position at Federal did in fact allow such freedom of movement and lack of heavy lifting.

not conveyed all relevant information; Metropolitan initiated such a review. Pursuant to this review, in August 1986 Dr. Smith contacted Metropolitan, again indicating that based upon his March 1986 examination, while Madden was limited to "semi-sedentary" work, he was not disabled for any occupation.[2] Specifically, while he was limited in his abilities to bend, lift, and stoop, he suffered no limitations regarding activities such as operating electrical equipment, concentrating visual attention, grasping, handling, and finger dexterity. Based on Dr. Smith's medical findings Metropolitan affirmed its decision to terminate Madden's Plan benefits, again requesting that Madden provide any medical information that would support his benefit claim.

Madden respondent by filing a complaint with the Office of the Washington State Insurance Commissioner. In response to this complaint, in January 1987 Metropolitan conducted a second review, reaffirming its decision to terminate Madden's Plan benefits, based upon Dr. Smith's medical findings and Madden's training, education, and experience.

In February 1987 Madden requested yet another review, at which time Metropolitan had an independent outside agency, Crawford Risk Management Services

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[2] Dr. Smith's letter indicated that "full-time semi-sedentary work would place too much stress on [Madden's] back." However, Dr. Smith testified at his deposition that his secretary erred and that the form should have indicated that full-time *sedentary* work, not semi-sedentary work, would place too much stress on Madden's back.

("Crawford"), perform a vocational assessment. Crawford reviewed Dr. Smith's medical findings, Madden's age, and his education, training, and experience. Crawford determined that Madden retained functional capacity to perform work within his capabilities, listing five job titles he should be capable of performing. Based on Dr. Smith's medical findings and Crawford's assessment, Metropolitan again reaffirmed its decision to terminate Madden's Plan benefits. At no time during these three reviews did Madden submit any additional medical evidence supporting his benefit claim.[3]

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[3] In his first request for review of Metropolitan's decision to terminate his Plan benefits, Madden referred to an alleged evaluation by the UCLA Medical Center and an alleged examination by Dr. Jean Michaels, an orthopedic specialist in Lompoc, California. Madden alleges that in May 1986 he mailed a copy of the social security award and Dr. Michaels' medical examination to Metropolitan. Beyond this reference and allegation, however, there is no evidence in the record supporting such an alleged mailing, the alleged examination by Dr. Michaels, or the alleged evaluation by UCLA Medical Center. Nor is there any evidence in the record showing Metropolitan's receipt of the alleged medical reports; Metropolitan's records show only a logged phone call from Madden informing Metropolitan of the social security benefit award. Moreover, neither alleged medical reports were submitted to the district court.

Regarding these alleged reports, the district court held that while perhaps Madden has some reports by other doctors somewhere, and that perhaps they might support his claim, they were irrelevant, since he did not get them to Metropolitan, despite Metropolitan's many requests for further medical information. We agree.

In April 1988 Madden filed suit against the Plan and Federal pursuant to ERISA, 29 U.S.C. § 1132(a)(1)(B),[4] to recover benefits allegedly due him under the terms of the Plan, seeking contractual damages, injunctive relief, and attorney's fees. The district court granted defendants' motion for summary judgment, ruling that Metropolitan's decision to terminate Madden's Plan benefits was reviewable under the "arbitrary and capricious" standard of review. The court found that Metropolitan's decision was not arbitrary and capricious, was supported by substantial evidence, was not made in bad faith, and was not erroneous as a matter of law, and that even if the decision were subject to *de novo* review, Metropolitan did not violate its fiduciary duty. The court also ruled that the Plan was entitled to the retroactive social security benefits Madden received for the period he also received Plan benefits. Lastly, the court ruled that Federal was not a proper party, because ERISA only permits suits for recovery of benefits against the employee benefit plan itself, not the employer. The court denied Madden's

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[4] Section 1132(a) provides in part:

A civil action may be brought –

(1) by a participant or beneficiary –

(A) . . .

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

ERISA, 29 U.S.C. § 1132(a)(1)(B) (1988).

cross-motion for summary judgment, which sought ERISA disability benefits on the theory that he was eligible because he received a social security award.

Madden appeals, contending that (1) Metropolitan's decision to terminate his Plan benefits should be reviewed under the *de novo* standard of review; (2) Metropolitan acted improperly in terminating his Plan benefits; (3) there are disputed issues of material facts; (4) he is entitled to summary judgment because he succeeded in his social security disability claim; (5) the Plan is not entitled to any of his retroactive social security benefits award; and (6) Federal is a proper party. Madden also requests attorney's fees on the appeal. We affirm.

B. *Standard of Review*

We review a grant of summary judgment *de novo*. *Kruso v. International Tel. & Tel. Corp.*, 872 F.2d 1416, 1421 (9th Cir. 1989), *cert. denied*, 110 S.Ct. 3217 (1990). We must determine, viewing the evidence in the light most favorable to the nonmoving party, whether there are any genuine issues of material fact and whether the district court correctly applied the relevant substantive law. *Tzung v. State Farm Fire and Casualty Co.*, 873 F.2d 1338, 1339-40 (9th Cir. 1989).

[1] Madden contends that Metropolitan's decision to terminate his Plan benefits should be reviewed under the *de novo* standard of review. Madden contends that even though ITT's decisions under the Plan are entitled to the "arbitrary and capricious" standard of review because ITT is the Plan's named fiduciary, Metropolitan's decision

to terminate his Plan benefits is not, because Metropolitan is merely ITT's delegate and not an ERISA fiduciary.

Under ERISA "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan." ERISA, 29 U.S.C. § 1102(a)(1)(1988).

In *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 953-57 (1989), the Supreme Court closely analogized the law under ERISA to trust law and ruled on the applicable judicial standard of review of ERISA claims: "[A] denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 956. Where such authority is given under trust principles a "deferential standard of review" is appropriate. *Id.* at 954.

Under ERISA, a named fiduciary may delegate its fiduciary responsibilities:

> The instrument under which a plan is maintained may expressly provide for procedures . . . (B) for *named fiduciaries to designate persons* other than named fiduciaries *to carry out fiduciary responsibilities* (other than trustee responsibilities) under the plan.

ERISA, 29 U.S.C. § 1105(c)(1) (1988) (emphasis added).

[2] In accordance with the logic and reasoning of *Firestone*, we hold that where (1) the ERISA plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan and (2) pursuant to ERISA, 29 U.S.C. § 1105(c)(1) (1988), a named fiduciary properly designates another fiduciary, delegating its discretionary authority, the "arbitrary and capricious" standard of review for ERISA claims brought under § 1132(a)(1)(B) applies to the designated ERISA-fiduciary as well as to the named fiduciary. *Accord Bali v. Blue Cross & Blue Shield Ass'n*, 873 F.2d 1043, 1047 (7th Cir. 1989) (where plan gives administrator discretionary authority regarding document requests and insurer acts as plan administrator, discretionary standard of review applied to insurer's document requests); *see Firestone*, 109 S.Ct. at 956; *see also Filary v. General Am. Life Ins. Co.*, 711 F.Supp. 528, 530 (D. Ariz. 1989) (insurer's benefit claim denial, based on discretionary authority to construe plan, reviewed under arbitrary and capricious standard).

In the present case the Plan named ITT as Plan administrator and fiduciary and expressly authorized ITT's Board of Directors to appoint a Long-Term Disability ("LTD") Administration Committee to have "responsibility for carrying out all phases of the Administration of the Plan." The Plan expressly gives the Committee discretionary authority to determine eligibility for benefits and to construe the terms of the plan:

> The LTD Administration Committee shall have *the exclusive right . . . to interpret the Plan and to decide any and all matters arising hereunder,*

> including the right to remedy possible ambiguities, equities, inconsistencies, or omissions. . . . [A]ll interpretations and decisions of the LTD Administration Committee or the [ITT] Board of Directors with respect to any matter hereunder shall be final, conclusive and binding on all parties affected thereby.

(emphasis added). *See also Firestone*, 109 S.Ct. at 956.

The Plan, as permitted by § 1105(c)(1), also expressly authorizes the LTD Administration Committee to designate another person as fiduciary for the administration of the Plan:

> The LTD Administration Committee *may delegate its authority with respect to the denial, granting, and administration of claims to a claim administrator,* which may be an insurance company or other appropriate named fiduciary and may enter into a Claims Administration Agreement with such claim administrator for the handling and determination of claims including, but not limited to, the granting or denial of claims and any appeals therefrom.

(emphasis added). *See also* ERISA, 29 U.S.C. § 1102(a)(1) (1988).

Pursuant to this provision ITT designated Metropolitan as Plan fiduciary and administrator pursuant to a Claims Administration Agreement effective January 1, 1986:

> Upon receipt of a claim, *Metropolitan shall review the claim* including evaluation by Metropolitan's consultants when required, and determined whether it has been properly filed and the amount, if any, which is due and payable with respect thereto. In making benefit payments, *Metropolitan will determine the validity of each*

> *claim presented* and will, as necessary, make appropriate investigations within the time prescribed for processing of claims. . . .
>
> . . .
>
> If benefits are to be wholly or partially denied, Metropolitan shall notify the claimant within a reasonable period of time. . . . *Metropolitan will have fiduciary responsibility for provision of full and fair review of claim denials.* . . . Final determination of payment or denial of appealed claims will be made following appropriate analysis and review. ITT will promptly submit to Metropolitan any request it receives for a review of a claim for benefits which has been denied, in order that Metropolitan may provide a full and fair review of the claim.

(emphasis added).[5] However, under the Claims Administration Agreement, ITT did retain ultimate discretion to construe the terms of the Plan:

> [I]n the event ITT determines that Metropolitan has misinterpreted the Plan and so informs Metropolitan in writing of such appropriate interpretation, and such interpretation is deemed not unreasonable and not inconsistent with the terms of the Plan to Metropolitan, all claims processed after delivery of such writing to Metropolitan shall be administered in accordance with the interpretation of ITT.

Because the Plan gives the LTD Administration Committee discretionary authority and the Committee has properly designated Metropolitan as ERISA fiduciary, we

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[5] Madden's claim that Metropolitan is not an ERISA fiduciary and thus is not entitled to any deference is clearly incorrect; the Claims Administration Agreement expressly provides that Metropolitan has fiduciary responsibility.

review Metropolitan's decision to terminate Madden's Plan benefits under the more deferential "arbitrary and capricious" standard. *See Firestone*, 109 S. Ct. at 956; ERISA, 29 U.S.C. § 1105(c)(1) (1988).

C. *Termination of Plan Benefits*

Madden contends that Metropolitan improperly terminated his Plan benefits, citing Metropolitan's failure to consider his social security award, *see Pierce v. American Waterworks Co.*, 683 F.Supp. 996, 1000 (W.D. Pa. 1988) (denial of benefits reversed as arbitrary and capricious in part because of the claimant's receipt of a social security award), and its reliance upon medical reports written in August and November of 1985, eight and five months before Metropolitan's decision to terminate his Plan benefits.

[3] In accordance with our above holding, we review Metropolitan's decision to terminate Madden's Plan benefits under the "arbitrary and capricious" standard. The record shows that Metropolitan's decision to terminate Madden's Plan benefits was based upon the most recent medical information in its files, provided by his own physician, Dr. Smith, which specifically noted that Madden was not totally disabled from work, and Federal's report of Madden's educational background and work experience. Although Metropolitan did not consider Madden's social security award, unlike *Pierce*, where the medical evidence contradicted the plan's decision to terminate plan benefits, in the present case all medical evidence submitted to Metropolitan and in the record shows that as of June 1, 1986 Madden was able to

engage in various occupations and thus failed to meet the Plan's definition of "totally disabled." We therefore conclude that Metropolitan's decision to terminate Madden's Plan benefits was not arbitrary or capricious and was supported by substantial evidence.

D. *Disputed Material Facts*

Madden next contends that the meaning of the phrase "total disability," the relevance of his social security award, the adequacy of Metropolitan's notification regarding the provision of information regarding perfection of his benefit claim, and the objectivity, independence, and fairness of Metropolitan's appeal procedure are all disputed material facts.

Madden first argues that the Plan's definition of "total disability," which requires that he be "unable to engage in *any* occupation" should not be given "an absolute and literal interpretation." *See Helms v. Monsanto Co.*, 728 F.2d 1416, 1420 (11th Cir. 1984) (rejecting "an absolute and literal interpretation" of the term "totally and permanently disabled").

In *Helms* the court defined "totally and permanently disabled" as a "physical inability to follow any occupation from which [one] could earn a reasonably substantial income rising to the dignity of an income or livelihood, even though the income is not as much as he earned before the disability." *Id.* at 1421-22. However, in the present case the Plan defines "totally disabled" as "unable to engage in *any* occupation for which [he is]

qualified, based on [his] training, education, or experience." (emphasis in original). The Plan's definition, therefore, which recognizes a claimant's personal training, education, and experience, favors a claimant far more than Madden's proposed *Helms* definition, which merely focuses on the likelihood of "a reasonably substantial income" that "approach[es] the dignity of a livelihood." *Id.* at 1421. Therefore, the definition of "total disability" is not a disputed material fact.[6]

Madden next argues that Metropolitan should have considered his social security benefits award in its decision to terminate his Plan benefits. *See Pierce*, 683 F.Supp. at 1000-01. However, as discussed above, the *Pierce* reasoning does not apply in the present case, and we find that Metropolitan's decision to terminate Madden's Plan benefits was not arbitrary or capricious and was supported by substantial evidence. Therefore, the relevance of Madden's social security benefit award is not a disputed material fact.

Madden next argues that Metropolitan did not adequately notify him regarding the provision of further medical information to support his benefit claim. Under

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[6] Metropolitan's use of the Plan definition was clearly proper, because as an ERISA fiduciary, Metropolitan was required to apply the terms of the Plan. *See* ERISA, 29 U.S.C. § 1104(a)(1)(D) (1988).

Moreover, we note that there is substantial evidence in the record that shows Madden would not be "totally disabled" under the *Helms* definition, as the record shows that he was capable of following many occupations from which he could earn a "reasonably substantial income." *See Helms*, 728 F.2d at 1421.

ERISA, adequate notice in writing must be provided to any participant whose benefit claim has been denied, which must set forth the specific reasons for the denial. ERISA, 29 U.S.C. § 1133(1) (1988). The record shows that Metropolitan promptly notified Madden of its decision to terminate his Plan benefits, indicating that his benefit claim was denied because he was no longer "totally disabled" under the Plan. The record also shows that in this notice Metropolitan instructed Madden as to the proper method of appeal, specifically requesting the submission of any additional medical reports that would support his claim. Furthermore, the record shows that in each of Madden's three appeals, Metropolitan repeated its request for any medical information that he wished to submit; he submitted none. We conclude that the adequacy of Metropolitan's notice to Madden regarding the provision of further medical information to support his benefit claim is not a disputed material fact.

Lastly, Madden argues that Metropolitan's appeal procedure is not objective, independent, or fair and is therefore biased. Under ERISA a participant whose benefit claim has been denied must be afforded a reasonable opportunity for a full and fair review by the fiduciary of the decision denying the benefit claim. ERISA, 29 U.S.C. § 1133(2) (1988). The record shows that Metropolitan conducted three separate, independent reviews by persons not involved in the original decision to terminate Madden's Plan benefits. As noted above, the record also shows that Madden had every opportunity to present medical evidence supporting his benefit claim, although he declined to do so. The record further shows that

Metropolitan brought in Crawford, an independent outside service, to assess Madden's benefit claim during the third review. We conclude that the objectivity, independence, fairness, and impartiality of Metropolitan's appeal procedure is not a disputed material fact.

E. *Madden's Cross-Motion*

Madden next contends that he is eligible for ERISA disability benefits because he received a social security disability award. *See Pierce*, 683 F.Supp. at 1000. As discussed in detail above, the *Pierce* reasoning does not apply in the present case, and we find that Metropolitan's decision to terminate Madden's Plan benefits was not arbitrary or capricious and was supported by substantial evidence. Moreover, if Madden's argument were correct, ERISA fiduciaries would be stripped of all administrative discretion, as they would be required to follow the Department of Health and Human Services' decisions regarding social security benefits, even where the Plan determines benefits under different standards or the medical evidence presented is to the contrary. Therefore, the district court properly denied his cross-motion for summary judgment.

F. *Retroactive Social Security Benefit*

Madden next contends that the Plan is not entitled to any of his retroactive social security award because such an entitlement constitutes a loss of his benefits. Under ERISA a summary plan description must list and explain the circumstances that may result in disqualification, ineligibility, or denial or loss of benefits. ERISA, 29 U.S.C.

§ 1022(b) (1988). However, courts have upheld the recovery of retroactive social security awards by ERISA plans where such plans provide for the reduction of benefits by such awards, even when the Plan does not specifically provide for such retroactive reimbursement. *See e.g., Stuart v. Metropolitan Life Ins. Co.*, 664 F.Supp. 619, 623-24 (D. Me. 1987), *aff'd*, 849 F.2d 1534 (1st Cir.), *cert. denied*, 488 U.S. 968 (1988) (failure to provide for recoupment of retroactive payments does not prevent such reimbursement where clear language of plan anticipates reductions in benefits upon receipt of social security award).

In the present case the Summary Plan Description ("SPD") specifically provides that the Plan's long-term disability benefits "may include disability benefits payable to you from any of the following sources: Workers' Compensation, *Social Security* and the Railroad Retirement Board [and] Other Plans." (Emphasis added) The SPD further provides that only benefits from the listed sources are included in the Plan benefit, and that once a participant begins receiving a long-term disability benefit, it will not be reduced by any increase in benefits the participant may be entitled to from other sources. The SPD also gives a specific example of the application of these provisions, showing a claimant entitled to 55% of his monthly salary prior to the disability, minus social security benefits payable to the claimant, not including benefits payable to the claimant's family.

[4] The SPD properly notified Madden as to the reduction of his Plan benefits by any social security disability benefits. *See* ERISA, 29 U.S.C. § 1022(b) (1988). Furthermore, there is no record evidence that Madden

was unaware of these provisions. Because the SPD provides for the reduction of Plan benefits by social security disability awards, the Plan is entitled to the retroactive social security benefits Madden received for the period he also received Plan benefits.

G. *Dismissal of Federal*

Lastly, Madden contends that Federal is a proper party in this matter because Federal allegedly canceled multiple insurance policies of his after Metropolitan terminated his Plan benefits. This Circuit has held that "[t]he only causes of action [a plaintiff] has are those provided by ERISA. ERISA permits suits to recover benefits only against the Plan as an entity, . . . and suits for breach of fiduciary duty only against the fiduciary." *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324-25 (9th Cir. 1985) (citations omitted). Madden's contention that he alleged non-ERISA claims against Federal is not borne out and, in any event, is mooted by our discussion on the ERISA issues. Therefore, Federal is not a proper party.

H. *Conclusion*

We affirm the district court's summary judgment ruling: (1) Metropolitan's decision to terminate Madden's Plan benefits was not arbitrary or capricious and was supported by substantial evidence; (2) there are no disputed material facts; (3) the Plan is entitled to the retroactive social security benefits Madden received for the period he also received Plan benefits; and (4) Federal is

not a proper party. Because we find in favor of defendants on the merits, we deny Madden's request for attorney's fees pursuant to ERISA, 29 U.S.C. § 1132(g)(1).

AFFIRMED.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

ERVIN B. MADDEN, Plaintiff, v. THE ITT LONG TERM DISABILITY PLAN FOR SALARIED EMPLOYEES; FEDERAL ELECTRIC CORPORATION, Defendants.	CV 88-02280 FFF (Sx) JUDGMENT (Filed Apr. 21, 1989)

This matter came on for hearing on April 17, 1989, on motion by Defendants the ITT Long Term Disability Plan for Salaried Employees and Federal Electric Corporation for Summary Judgment. Steve Roseman appeared on behalf of Plaintiff. John L. Viola appeared on behalf of Defendants.

The Court has considered the papers, evidence and argument submitted in support of the opposition to the motion. The Court, having entered its Findings of Fact and Conclusions of Law, concludes that there is not genuine dispute as to any material fact. Thus, Defendants are entitled to summary judgment as a matter of law.

Therefore, it is HEREBY ORDERED, ADJUDGED AND DECREED that Defendant's motion for summary judgment be, and is, hereby *GRANTED*, that Plaintiff take nothing, that the action is dismissed on its merits, that Defendant ITT shall recover from Plaintiff Ervin B. Madden $19,546.27 for overpayment of benefits and its costs of suit.

DATED: April 21 1989

/s/ Ferdinand F Fernandez
FERDINAND F. FERNANDEZ
United States District Judge

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

ERVIN B. MADDEN, Plaintiff, v. THE ITT LONG TERM DISABILITY PLAN FOR SALARIED EMPLOYEES; et al., Defendants.	CV 88-02280 FFF (Sx) STATEMENT OF UNCONTROVERTED FACTS AND CONCLUSIONS OF LAW (Filed Apr. 21, 1989)

This matter was set for hearing on April 17, 1989, on motion by Defendants ITT Long Term Disability Plan ("ITT") and Federal Electric Corporation for Summary Judgment. Steven Roseman appeared on behalf of Plaintiff. John L. Viola appeared on behalf of Defendants.

The Court has considered the papers and evidence of the parties and hereby enters the following statement of uncontroverted facts and conclusions of law.

STATEMENT OF UNCONTROVERTED FACTS

1. Plaintiff Ervin B. Madden is an individual and a citizen of California.

2. Defendant Federal Electric Corporation is a California corporation authorized to do business in California.

3. Defendant ITT is an employee benefits plan providing long term disability benefits to salaried employees of Federal pursuant to and governed by The Employee

Retirement Income and Security Act of 1974, 29 U.S.C. § 1100 *et seq.* ("ERISA").

4. Plaintiff seeks long term disability benefits under the plan retroactive to June 1, 1986, for an alleged disability due to a back injury occurring in February, 1983.

5. The Plan provides two definitions of "total disbility [sic]" for purposes of receiving long-term disability benefits.

> 1. During the first year in which you receive LTD [(Long term disability)] benefits you are considered totally disabled if you are unable to perform the regular duties of your ITT job and are not employed elsewhere.
>
> 2. After the first year, total disability means you are unable to engage in *any* occupation for which you are qualified based on your training, education or experience.

6. Prior to January 1, 1986, The Equitable Life Assurance Society of the United States ("Equitable") processed claims under and served as claim fiduciary for the Plan, which is self-insured. On or after January 1, 1986, Metropolitan Life Insurance Company ("Metropolitan") served in this capacity. The Plan allowed for a delegation of some of the duties, but ITT retained ultimate authority to rule on eligibility questions.

7. Plaintiff's attending physician informed Equitable that Plaintiff was disabled under *both* of the Plan's definitions of total disability for the period September, 1983, through August, 1985, and, accordingly, Plaintiff received Plan benefits for the period of August, 1983, through May, 1986.

8. In August, 1985, Plaintiff's attending physician, Dr. Smith, indicated that while Plaintiff was totally disabled from his own job, he was not longer totally disabled from any other work. Rather, Dr. Smith indicated that Plaintiff could perform "semi-sedentary" work.

9. In November, 1985, Dr. Smith repeated his finding that Plaintiff was not totally disabled from work, other than his own job at Federal Electric. Dr. Smith cconcluded [sic] that Plaintiff should be able to do "semi-sedentary" work: "If the job allows [Plaintiff] to stand up frequently after no more than 30 minutes sitting at a time and does not require him to lift more than ten pounds, he should be able to peform [sic] the job as required."

10. Plaintiff, as indicated by his own resume, has extensive education and experience in communications and electronics, including supervisory positions. Indeed, his own job at Federal Electric allowed him the freedom of movement, with no heavy lifting, prescribed by Dr. Smith.

11. Based on Dr. Smith's findings – the only current medical information on file – and Plaintiff's training, education and experience, Metropolitan determined that he was no longer "totally disabled" as defined by the Plan, and terminated Plan benefits effective June 1, 1986.

12. Plaintiff requested that Metropolitan review the decision, claiming that Dr. Smith had not conveyed all relevant medical information. In August, 1986, pursuant to its review, Metropolitan received another statement from Dr. Smith. Again, as in his August, 1985, and November, 1985, statements, Dr. Smith indicated that while limited to "semi-sedentary" work, Plaintiff was *not*

disabled for "any occupation." Dr. Smith also indicated that while there were some limitation on Plaintiff's ability to engage in physical activities such as bending, lifting and stooping, there were no limitations on other activities such as operating electrical equipment, concentrated visual attention, grasping, handling and finger dexterity, functions important in the fields of communications and electronics. Based on Plaintiff's physical limitations, as described by Dr. Smith, which findings are the only current medical information in its file, Metropolitan affirmed its decision and requested that Plaintiff provide it with any medical information which would support his claim.

13. Instead of providing such additional evidence, Plaintiff filed a complaint with the State of Washington Office of Insurance Commissioner. In response to the Complaint, Metropolitan conducted a second independent review in January, 1987, and reaffirmed its decision based on Dr. Smith's findings considered in light of Plaintiff's training, education and experience.

14. Plaintiff requested yet another review of his claim in February, 1987. Pursuant to this request, Metropolitan had a vocational assessment performed by an independent outside agency, Crawford Risk Management Services ("Crawford"). Based on Dr. Smith's medical reports, Plaintiff's age, and Plaintiff's education, training and experience, Crawford determined that he retained the functional capability to perform work within his capabilities and listed five job titles he should be capable of performing. Based on Crawford's assessment and Dr. Smith's reports – still the *only* medical reports on file – Metropolitan affirmed its original decision to terminate benefits a third time.

15. Plaintiff did not submit any medical reports in support of his claims after the July, 1986, report of Dr. Smith.

16. The Plan provides that Plan benefits payable to a Plan participant are to be reduced by, among other things, Social Security Disability Income Benefits ("SSDIB") payable to the claimant.

17. Although Plaintiff was originally denied SSDIB, he was awarded SSDIB in October, 1985, retroactive to August, 1983. The details of this award were not made available to the Plan, Federal Electric or Metropolitan until after the inception of this action and, therefore, the Plan benefits [paid to Plaintiff] were not reduced by the amount of SSDIB benefits as required by the terms, provisions and conditions of the Plan.

18. As a result, Plaintiff has been overpaid $19,546.27 in Plan benefits.

19. Any statement of fact inappropriately designated as a conclusion of law is incorporated herein.

CONCLUSIONS OF LAW

1. The Court has subject matter jurisdiction over this action pursuant to 29 U.S.C. § 1132(e) and 28 U.S.C. § 1331.

2. The Court has personal jurisdiction over the parties. Venue is proper in this district.

3. Summary judgment is proper "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and

on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett*, ___ U.S. ___, 106 S.Ct. 2548, 2652-53 (1986).

4. Where the plan provides that the administrator retains discretion to determine eligibility for benefits or to construe the terms of the plan the trustees' actions should be judged under traditional trust law, i.e. essentially an arbitrary and capricious standard. Where the administrator does not have such discretion, his decisions should be reviewed de novo. *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989).

5. An ERISA trustee may delegate his authority if the plan so provides, but still retains ultimate responsibility for the acts of his delegatee with respect to the welfare of the beneficiary. Thus in approving the acts of the delegatee the trustee is bound by those acts and their consequences. 29 U.S.C. § 1105; *Credit Managers Ass'n v. Kennesaw Life & Acc. Ins.*, 809 F.2d 617 (9th Cir. 1987).

6. Metropolitan, as ITT's delegatee, provided the plaintiff with three opportunities for review of his claim. Metropolitan also solicited additional medical information from Madden. Plaintiff did not provide objective documentation by a physician of his subjective complaints. The firm reviewed all of the information which it had in its files on Madden's educational background, his work experience and his medical condition. In addition, Metropolitan obtained further analysis of the record before it by Crawford.

7. Although it did not conduct an independent review of Madden's claim, ITT accepted and thus ratified Metropolitan's decision to terminate payment of Plan

benefits to Plaintiff. The extensive opportunity for review and the requests for additional information reflect a careful handling of Mr. Madden's claim. Thus, Metropolitan's conduct, adopted by ITT, was not arbitrary and capricious, was supported by substantial evidence, was not made in bad faith and was not erroneous as a matter of law.

8. Even if this Court concluded that the real issue was Metropolitan's conduct as claim fiduciary, the company's handling of the claim would pass muster. Since Metropolitan did not have ultimate discretion under the plan, *Firestone* indicates that a de novo review would be appropriate. Even under this more stringent standard Metropolitan behaved as a proper fiduciary. As described above, the company was thorough and circumspect in reviewing the information which it had before it and in trying to elicit additional relevent data from the claimant. Thus, even reviewing the claims process de novo the Court concludes that Metropolitan did not violate its fiduciary duty under ERISA.

9. ERISA only permits suits for recovery of benefits against the employee benefit plan itself. *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323 (9th Cir. 1985).

10. Defendant Federal Electric is thus not a proper party to this suit.

11. The Plan is entitled to a refund of overpayments of $19,546.27. *Stuart v. Metropolitnan [sic] Life Ins. Co.*, 664 F.Supp. 619 (Me. 1987), *aff'd* 849 F.2d 1534 (1st Cir. 1988), *cert. denied*, ___ U.S. ___, 109 S.Ct. 496, 102 L.Ed.2d 533 (1988).

12. Accordingly, Defendant's motion for summary judgment is hereby *GRANTED*.

13. Any conclusion of law inappropriately designated as a statement of fact is incorporated herein.

14. The Court incorporates its comments from the bench on April 17, 1989, as further explanation of its determination.

DATED Apr. 21, 1989

/s/ Ferdinand F. Fernandez
FERDINAND F. FERNÁNDEZ
United States District Judge

Long Term Disability Benefits For You

Salaried Employees

January 1, 1981 ITT

Table of Contents

Introduction

This booklet describes ITT's Long Term Disability (LTD) Plan benefits. The plan is designed to provide you with a monthly income if a disabling illness or injury prevents you from working for an extended period of time. The benefits from the plan – combined with certain other sources of income that may be payable after a disability occurs – will be 55% of your monthly salary.

Benefits begin after you have been totally disabled for six consecutive months, and continue for as long as you are eligible. In addition, any benefits you receive under the plan are not subject to income tax, since your contributions pay for the entire cost of the plan.

The sections that follow describe the major provisions of the LTD plan. For further information, contact your local Personnel Department.

Membership

Eligibility

If you are an active, full-time, U.S. salaried employee of a participating ITT unit, you are eligible for membership in the LTD plan after you complete one month of service, provided you are under age 69½ years of age at that time.

If you are not a U.S. citizen, you may participate only while you are working in the U.S. If the terms and conditions of your employment are covered by a collective bargaining agreement, you are not eligible to participate in the plan.

How to Enroll

To join the plan, you must complete an enrollment card, giving ITT authorization to deduct your monthly LTD plan contribution from your paycheck. It's important to enroll within 31 days after becoming eligible. If you wait more than 31 days, you will be required to submit medical evidence of good health at your own expense.

When Coverage Begins

Coverage is in effect as of your first day of work following the one-month eligibility period, provided you were at work for seven consecutive days immediately prior to the effective date (with the exception of certain pre-existing conditions as described on page 6).

How the Plan Works

Definition of Disability

Under the terms of the LTD plan, there are two standards of disability qualifications: (1) During the first year, and (2) After the first year.

1. During the first year in which you receive LTD benefits you are considered totally disabled if you are unable to perform the regular duties of your ITT job and are not employed elsewhere.

2. After the first year, total disability means you are unable to engage in *any* occupation for which you are qualified, based on your training, education, or experience.

When Benefits Are Payable

Monthly LTD benefits begin after you have been *totally disabled* for six consecutive months, provided you have been under the care of a licensed physician. How long your monthly benefits continue depends upon your age at the time you become disabled. Payments will continue until the *earlier* of the date you recover from the disability, or for the period shown in the table below.

If your Age At Date of Disability Is:	Benefits Will Be Paid:
61 or less	to age 65
62	3 years
63	2 years 6 months
64	2 years
65	1 year 6 months
66	1 year 6 months
67	1 year
68	1 year
69	up to age 70

Regardless of when your disability begins, benefit payments will *not* be made past the end of the month in which you reach age 70. Also, your LTD benefits may end before the date shown on the schedule if you fail to continue to meet the plan's definition of disability (see above).

Benefit Amount

The LTD plan has been designed to provide you with a monthly income equal to 55% of your *base monthly salary,* up to $5,000 per month. Your base monthly salary is your regular compensation, not including overtime, foreign service premiums, allowances, or other special forms of compensation. If you receive all or part of your earnings in the form of commissions, your Personnel Manager will inform you how the amounts of your payroll deduction and benefits will be determined.

Minimum Benefit

The plan provides a minimum benefit of 20% of your base monthly salary, or 1/5 of your earnings, regardless of how much you might receive from other sources. (A more detailed explanation of "Other Disability Income Benefits" appears below).

Your monthly benefit is simply:

55% of you base monthly salary up to $5,000 per month

MINUS

Any other monthly disability income, as explained below

Other Disability Income Benefits

Your benefit from the LTD plan may include disability benefits payable to you from any of the following sources:

- Workers' Compensation
- Social Security and the Railroad Retirement Board

- Other Plans, including disability or pension benefits any employer contributes to, or makes payroll deductions for, any employer disability income plan, or any benefits payable under any state law or similar governmental law, foreign or domestic.

Only the benefits payable from these sources on your behalf are included in your plan benefit. Benefits payable on behalf of your *family members* are *not included.* In addition, once you have begun receiving an LTD benefit, it will not be reduced by any increase in benefits you may be entitled to from other sources.

Example of a Disability Benefit

Suppose your base monthly salary was $1,200 a month and you qualified for a Social Security disability benefit of $400 a month. Your monthly LTD benefit would be:

$1,200 times 55%	$660
Minus: Social Security payable to you (not including benefits payable to your family)	-400
Benefit from the LTD plan	$260

Since $260 is greater than the amount you would receive under the plan's minimum benefit provision (20 percent of $1,200 or $240), you would receive $260 per month from the LTD plan for as long as you remained disabled.

Your Contributions

Your contributions for LTD coverage are made through convenient payroll deductions. How much you pay is based on your salary, as shown on the following table:

EMPLOYEE CONTRIBUTIONS

If Your Basic Annual Salary Is		Your Contribution If You Are Paid	
At Least	But Less Than	Monthly	Weekly
$	$ 4,500	$ .84	$ .19
4,500	5,500	1.06	.24
5,500	6,500	1.35	.31
6,500	7,500	1.64	.38
7,500	8,500	2.18	.50
8,500	9,500	2.72	.63
9,500	10,500	3.26	.75
10,500	11,500	3.80	.88
11,500	12,500	4.34	1.00
12,500	13,500	4.88	1.13
13,500	14,500	5.42	1.25
14,500	15,500	5.96	1.38
15,500	16,500	6.75	1.56
16,500	17,500	7.53	1.74
17,500	18,500	8.32	1.92
18,500	19,500	9.10	2.10
19,500	20,500	9.89	2.28
20,500	22,500	11.06	2.55
22,500	24,500	12.63	2.91
24,500	26,500	14.20	3.28
26,500	28,500	15.77	3.64
28,500	30,500	17.34	4.00
30,500	32,500	18.91	4.36
32,500	34,500	20.48	4.73
34,500	36,500	22.05	5.09
36,500	38,500	23.62	5.45
38,500	40,500	25.19	5.81
40,500	42,500	26.76	6.18
42,500	44,500	28.33	6.54
44,500	46,500	29.90	6.90
46,500	48,500	31.47	7.26
48,500	50,500	33.04	7.62

For salaries beyond the ranges shown above, the cost is approximately $1.57 per month or $.36 per week for each additional $2,000 of salary, to a maximum contribution of $79.75 per month or $18.40 per week.

Your LTD contribution will automatically change when your salary changes.

Waiver of Contributions

You will not be required to pay contributions during any period in which you receive LTD benefits.

Separate Periods of Disability

A separate period of disability occurs every time your disability is due to a different and unrelated cause, and is separated by a return to work. However, if you receive LTD benefits, return to work for less than six months, then become totally disabled again, both periods of disability are considered as one. If you returned to work for at least six months, you must again meet plan requirements for payment of benefits, as defined on Page 3 before you can receive benefits for any subsequent period of disability.

When Coverage Ends

Normally, your LTD coverage will continue until:

- you are no longer eligible.
- you voluntarily cancel your payroll deduction authorization, in which case coverage stops the last day of the period covered by your final contribution.

- your employment with ITT terminates, in which case coverage ends on your last day of work, or
- you are temporarily laid-off or take a leave of absence without pay, in which case coverage stops on your last day of work.

Limitation and Exclusions

Pre-existing Conditions. Coverage for a pre-existing condition will not start until you have completed a twelve month period of continuous employment, during which you have no absences from work due to that condition. A pre-existing condition is an accident or illness for which you have had medical treatment during the three months prior to becoming a plan member. Pregnancy is also considered a pre-existing condition.

Excluded Disabilities. Benefits from the LTD plan are not payable for any disability that results from:

- intentionally self-inflicted injury,
- injuries or sickness for which you are not treated by a licensed physician.
- injuries received while participating in an illegal act, or
- injuries or illnesses sustained in a war or any act of war.

Other Information You Should Know

Only the principal features of the ITT Long Term Disability Plan have been presented in this booklet.

In addition, there is other information you are entitled to know, as required by the Employee Retirement

Income Security Act of 1974 (ERISA). The information on the following pages, together with the information already presented in this booklet, constitute the summary plan description as required by the ERISA law.

ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all plan documents, and copies of all documents filed with the U.S. Department of Labor by the plan, such as annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may impose a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the plan, such as the Plan Administrator and Trustees. These persons are referred to as fiduciaries. Fiduciaries must act solely in the interest of the plan participants and they must exercise prudence in the performance of their plan duties.

ERISA specifically provides for circumstances under which you may take legal action as a plan participant.

1. If you are improperly denied a benefit, in full or in part, to which you are entitled, you have a right to file suit in a federal court.

2. If the plan fiduciaries misuse the plan's funds or if you are discriminated against for asserting your rights, you have a right to seek assistance from the U.S. Department of Labor or to file suit in a federal court.

In these circumstances, the court will decide who should pay court costs and legal fees. In other words, if you are successful, the court may order the party you have sued to pay these costs and fees. But if you lose, the court may order you to pay the costs and fees (for example, if it finds your claim is frivolous.)

Plan Name:	ITT Long Term Disability Plan for Salaried Employees
Participants:	The benefits in this booklet apply to all regular, full-time, U.S. salaried employees of designated ITT divisions and subsidiaries and units thereof who enroll in the plan.
Employer Identification No.:	13-5158950
Plan Number:	802
Plan Administrator:	International Telephone and Telegraph Corporation 320 Park Avenue New York, NY 10022 (212) 752-6000
Plan Records:	ITT maintains a financial record for the plan based on a fiscal year ending December 31st of each calendar

year. The records for the plan are maintained at the office of the Plan Administrator.

Funding: All benefits payable to participants for disabilities occurring after December 31, 1980 are derived from the ITT Benefit Trust, and are funded entirely by employee contributions.

Plan Continuation

ITT intends to continue this plan indefinitely, but reserves the right to amend or discontinue it at anytime. If ITT terminates the plan for any reason and does not replace the coverage with comparable benefits, you will receive adequate notice. Payment of benefits for disabilities commencing before plan termination will be arranged for by ITT.

Agent For Service of Legal Process

Service of legal process may be made on the Plan Administrator or:

Corporate Secretary
International Telephone and Telegraph
Corporation
320 Park Avenue
New York, New York 10022

How To File A Claim

To receive LTD benefits you must follow the appropriate claims procedure. If you become disabled and it seems likely that your illness or injury will continue for an extended period of time, contact your local Personnel Department who will give you any help you may need in

processing your claim for LTD benefits. Claim determinations will be made by the Equitable Life Assurance Society of the United States.

If any benefits are denied in whole or in part, or if any additional information is required, you will be notified in writing.

If A Claim Is Denied

If you believe you are entitled to receive benefits, and do not agree with the reason given as to why your benefit was denied in whole or in part, you may file a claim in writing with the person who wrote to you advising you of the denial. The claim should state your name and address, facts supporting the claim, and any appropriate data. The decision concerning your claim will be reviewed, and you will be advised of the results of the review, in writing, within 60 days of the date your appeal is received. If there are special circumstances you will be notified within 120 days. If you are not satisfied with the final decision and you wish to review documents pertinent to your appealed claim, contact the office that processed your claim.

Everything contained in this summary description is believed to be a fair and accurate summary of the ITT Long Term Disability Plan for Salaried Employees, but does not cover all details. If there is a conflict, the provisions of the plan will prevail. If you have any questions about this plan, this statement, or your rights under ERISA, contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

ADMINISTRATIVE SERVICES AGREEMENT

Entered into between

ITT CORPORATION
NEW YORK, NEW YORK
(hereinafter "ITT")
and
METROPOLITAN LIFE INSURANCE COMPANY
New York, New York
(hereinafter "Metropolitan")

WHEREAS, ITT has adopted the ITT Long Term Disability Plan for Salaried Employees for the purpose of providing long term disability benefits for certain of its employees as set forth in Appendix A (hereinafter the "Plan"); and

WHEREAS, ITT has entered into a trust agreement with Manufacturers' Hanover Trust Company as Trustee for the ITT Employee Benefit Trust, as set forth in Appendix B (the "Trustee" and the "Trust," respectively), as a funding medium for the Plan, under Section 501(c)(9) of the Internal Revenue Code; and

WHEREAS, the ITT Employee Benefit Trust Administration Committee has been appointed by ITT's Board of Directors with responsibility for carrying out all phases (except asset Management) of the ITT employee welfare benefit programs included under such Trust; and, pursuant to such appointment, the ITT Employee Benefit Trust Administration Committee has responsibility for carrying out the administration of the Plan and is deemed, and acts as, the LTD Administration Committee ("the Committee"), a named fiduciary under such Plan except for review of claim denials under the Plan pursuant to Section 503 of the Employee Retirement Income

Security Act of 1974 and amendments thereto (hereinafter ERISA); and

WHEREAS, ITT wants Metropolitan to furnish services necessary in the administration of certain aspects of the Plan; and

WHEREAS, Metropolitan is willing to provide such services in accordance with the terms of this Agreement and ERISA, without assuming any liability of ITT under the Plan, except obligations as may be imposed upon Metropolitan by applicable law or pursuant to the terms of this Agreement; and

WHEREAS, it is the purpose of this Agreement to set forth the terms and conditions under which Metropolitan shall furnish the following services for ITT pursuant to the Plan: (i) receiving and processing claims for benefits under the Plan, as defined herein, (ii) disbursing claim payments under the Plan on account of such claims, (iii) acting as the appropriate named fiduciary for review of claim denials under the Plan pursuant to Section 503 of ERISA and (iv) performing such additional duties as set forth herein.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, it is agreed as follows:

Article I. Services Provided

Metropolitan will perform services and provide supplies, forms and materials in connection with the administration and operation of the Plan in its entirety, as set forth below:

A. Administrative Services

1. Furnish advice and assistance in a consultative capacity at the request of ITT with regard to the design of the Plan and the design of any subsequent revisions in the Plan, including advice and assistance with respect to Plan provisions relating to eligibility, effective dates and cessation of coverage.

2. Furnish advice and assistance in a consultative capacity at the request of ITT with regard to the preparation and review of plan documents, such as descriptive booklets, summary plan descriptions and similar material for distribution by ITT to eligible employees.

3. Prepare and furnish the following reports summarizing financial experience:

   (a) Weekly summary of drafts drawn, amount of drafts, drafts voided, refunds and drafts paid.

   (b) Monthly reconciliation of weekly summaries.

   (c) Monthly and annual reports of claims paid.

   (d) Monthly and annual summaries of drafts not presented for payment, including drafts which were cancelled.

4. Furnish periodic advice and assistance in preparing ERISA forms required for reporting and disclosure.

5. Assist in establishing standard banking arrangements to provide for the payment of benefits under the Plan.

6. Furnish standard statement of health forms to obtain required information as to the health of any employee to establish that employee's eligibility to participate in the Plan or to increase

benefits thereunder, and provide recommendations regarding acceptability of evidence of insurability in cases of late enrollment, reinstatement of coverage, or increase in benefits. Metropolitan will also, at the expense of the employee, arrange for and evaluate medical examinations of those employees. The final decision to approve or deny coverage will be made by Metropolitan.

7. Prepare and maintain standard administration manuals.

8. Maintain a comparison of (a) the hypothetical premiums that would have been charged if the benefits under the Plan were insured with (b) the actual claims and fees paid under this Agreement. A summary of this comparison will be furnished to ITT on request.

9. Confer with ITT in a consultative capacity at the request of ITT on specific questions concerning taxes, employee benefit coverage and other matters which might affect the administration of the Plan.

10. Furnish recommendations regarding the design and format of statement of health forms for late enrollment, reinstatement of coverage, or increase in benefits.

11. Consult with ITT on communications with employees concerning enrollment in the Plan and changes in benefits or coverage provided under the Plan.

12. When a bank other than The Chase Manhattan Bank, N.A., Crocker National Bank or Royal Bank of Canada is selected under Article II, Metropolitan will at ITT's expense, work with the bank to make any necessary adjustments in the bank's computer system to accommodate payment of claims under this Agreement.

13. Prepare and file reports for escheat of uncashed drafts for benefits for those states with applicable escheat laws and make payment out of the ITT special bank account in connection therewith.

14. At ITT's expense, arrange for and provide the printing of special forms utilized in connection with the administration of the Plan.

B. Actuarial and Technical Services

1. Furnish an estimate of the liability at the close of each Experience Period both for claims currently in payment status and estimated claims incurred but not reported.

2. Furnish annually an estimate for budget purposes of claim costs and fees for the following Experience Period.

3. Furnish claim cost calculations for changes or proposed changes in the Plan.

4. Furnish an estimate of the approved claim liability at the close of of [sic] each Experience Period.

5. Calculate hypothetical premium rates that would have been charged if the benefits under the Plan were insured.

6. Furnish a breakdown of estimates, calculations or evaluations provided under paragraph B on a unit basis.

7. Calculate hypothetical special accrual rates for budget purposes, to be delivered during the fourth quarter of each calender year.

C. Claim Services

1. Furnish advice and assistance on procedures to be followed for verification of employee coverage and for submission of claims.

2. Provide standard forms necessary for submission and processing of claims. At the request of ITT and at ITT's expense, prepare and furnish specially designed claim forms.

3. Upon receipt of a claim, Metropolitan shall review the claim including evaluation by Metropolitan's consultants when required, and determine whether it has been properly filed and the amount, if any, which is due and payable with respect thereto. In making benefit payments, Metropolitan will determine the validity of each claim presented and will, as necessary, make appropriate investigations within the time prescribed for processing of claims pursuant to Section 503 of ERISA and amendments thereto and by regulations of the Department of Labor promulgated thereunder.

4. Arrange for independent medical examinations and/or mercantile reports as required by Metropolitan. Medical examinations of claimants will be performed by physicians not directly associated with Metropolitan's Medical Department. These examinations will be performed by Board Certified Specialists when deemed appropriate by Metropolitan.

5. Compute and verify the amount of benefits, and prepare and furnish to each claimant an appropriate statement of the amount of benefits.

6. Issue drafts in payment of approved claims on a monthly basis, and provide for issuance of special drafts when required because of adjustment in benefits.

7. If benefits are to be wholly or partially denied, Metropolitan shall notify the claimant within a reasonable period of time, in conformance with the Plan and regulations of the Department of Labor pursuant to Section 503 of ERISA except that in case of conflict between the Plan and the

regulations, the regulations shall control. Metropolitan will have fiduciary responsibility for provision of full and fair review of claim denials pursuant to Section 503 of ERISA. Final determination of payment or denial of appealed claims will be made following appropriate analysis and review. ITT will promptly submit to Metropolitan any request it receives for a review of a claim for benefits which has been denied, in order that Metropolitan may provide a full and fair review of the claim.

8. To the extent required by law, provide for withholding of income taxes from disability benefit payments and remittance to Internal Revenue Service.

9. Prepare individual income tax reports for each employee on disability income payments and withholding and deliver the reports to each employee, the IRS and/or other taxing authority.

10. Furnish advice to claimants both on how to initially apply for United States Social Security Disability Insurance benefits and how to appeal denial of Social Security Disability Insurance benefits.

11. Administer reduction of benefits in accordance with the provisions of the Plan.

12. It is mutually understood that the effective performance of this Agreement by Metropolitan will require that ITT certify on each claim form, prior to submission to Metropolitan, the eligibility of the claimant for benefits under the Plan. ITT shall also cause to be furnished to Metropolitan such other information as may reasonably be required for the proper administration of the Plan. It is mutually agreed that Metropolitan shall not be responsible for delays in the performance of this Agreement or for the

non-performance of this Agreement, to the extent that such delays or non-performance are caused by failure of ITT to furnish any such information.

13. To the extent permitted by law and when the claimant has furnished an appropriate authorization, if required by law, furnish to ITT copies of benefit statements prepared for claimants.

14. At the request of ITT and at ITT's expense, provide the services of Claim Consultants to advise and assist on matters relating to claims.

15. At the request of ITT and at ITT's expense, conduct independent studies or reviews of ITT's existing procedures or systems for handling claims.

16. In the administration of claims under this Agreement, Metropolitan will follow the claim standards developed by Metropolitan for processing of Long Term Disability claims in connection with its administrative services business unless another interpretation is to be applied pursuant to the following paragraph.

    The determination of the extent of the benefits to which any claimant is entitled under the Plan shall initially rest with Metropolitan. However, in the event that ITT determines that Metropolitan has misinterpreted the Plan and so informs Metropolitan in writing of the appropriate interpretation, and such interpretation is deemed not unreasonable and not inconsistent with the terms of the Plan to Metropolitan, all claims processed after delivery of such writing to Metropolitan shall be administered in accordance with the interpretation of ITT, set forth in such writing.

D. Group Office Services

A Metropolitan representative will perform the following services:

1. Act as liaison with administration, technical services, claims and other departments of Metropolitan.
2. Assist in developing plan design.
3. Furnish to ITT bulletins, Perspectives, and White Papers.
4. Obtain price quotations for extra services.
5. Place orders for extra services.
6. At the request of ITT and at ITT's expense, participate in Plan adjustment due to mergers, spin-offs, extensions, acquisitions, and divestitures.

E. General

At the request of ITT and at ITT's expense, Metropolitan's personnel will travel to locations specified by ITT to provide administrative, actuarial, technical and claim services.

F. Statistical Services (Illustrative only)

1. Prepare and furnish to ITT the following statistical reports:

(i) LTD payment report

(ii) LTD overpayment report

(iii) LTD statistical report

G. Other Services

Metropolitan shall provide such other services as may be negotiated between ITT and Metropolitan.

Article II. Payment of Claims – Special Bank Account

A. To implement the Plan, ITT will arrange for the establishment of a special bank account at a financial institution to be selected by mutual agreement between ITT and Metropolitan. Benefits under the Plan will be paid by drafts drawn by Metropolitan against that special bank account.

B. ITT will direct the Trustee to make deposits of Plan Trust assets into the special bank account of such amounts and at such intervals as are required to discharge Plan liabilities. Whenever the deposit balance of this account is insufficient to cover drafts drawn by Metropolitan to pay benefits under the Plan, as required by Article I, an overdraft situation results. If Metropolitan in its sole discretion, although not required to do so, arranges at its expense and using its funds for funding with respect to any overdraft, ITT is obligated to reimburse Metropolitan for the amount of any such overdraft. In addition to this, a charge may be made by Metropolitan for arranging this funding. This charge will be determined monthly at an annual rate equal to the daily prime rate plus 4%, applied to the outstanding overdraft balance for each day for which the bank account is overdrawn. The daily prime rate will be the rate then being charged by the Chase Manhattan Bank, N.A.. Metropolitan will inform ITT of the existence and the amount of such charge at the time it is computed. The amount of such charge will be payable to Metropolitan with the next following monthly payment of the estimated fee, as described in Section B of Article III.

C. The identification of the special bank account, the nature and frequency of reports on the activity of the account, details regarding the mechanics of processing individual drafts drawn against the account and

information to appear on such drafts, and the retention of accepted drafts will be implemented by agreement between ITT, Metropolitan and the financial institution selected.

Article III. Service Fees

A. Metropolitan's fee for the services that Metropolitan is required to perform during an Experience Period (as defined in paragraph G of Article IV) is the sum of:

(1) $98 per new claim approval

(2) $160 per outstanding claim at the end of the Experience Period

(3) $52,500 to cover all other services outside of the claim activity including actuarial services and the fiduciary for appeal of denied claims.

Additionally first year only Service Fees:

(1) $50/hour for loading the existing claim files onto Metropolitan's claim adjudication system.

(2) $50/hour for reviewing existing claim files for continued disability status, Social Security eligibility, and rehabilitation potential.

If the fee for either of the tasks identified in subparagraph 1 or 2 is expected to separately with respect to each subparagraph exceed $25,000, Metropolitan will advise ITT of that fact.

B. As of the beginning of each Experience Period, Metropolitan will notify ITT of Metropolitan's estimate of the amount of the service fee for that Experience Period. The estimated monthly fee for the first month that this Agreement is in effect is due on the effective date of this Agreement, and the estimated fee for any subsequent calendar month is due on the fifteenth day of that calendar month. The estimated fee for

any calendar month is payable on or prior to its due date. If the payment of such estimated fee is made after its due date, it shall be subject to an interest charge for the period from the due date to the date payment is received by Metropolitan. The rate of interest charged shall equal the rate from time to time used by Metropolitan in its insurance business for delayed premium payment.

C. Within ninety (90) days following the end of each Experience Period, Metropolitan will notify ITT of the amount of the service fee for that Experience Period determined in accordance with Paragraph A of this Article. If (1) the service fee so determined, exceeds (2) the aggregate of the estimated monthly fees paid by ITT for the Experience Period pursuant to paragraph B of this Article exclusive of any additional charges as may be payable under this Agreement, then the excess will be payable by ITT to Metropolitan. Such payment will be part of ITT's regular monthly payment for the month following notification by Metropolitan of the amount so payable. If the payment of any such excess is made after the fifteenth day of the next month, it shall be subject to an interest charge for the period from the due date to the date payment is received by Metropolitan. The rate of interest charged shall equal the rate from time to time used by Metropolitan in its insurance business for delayed premium payments. All additional charges payable under this Agreement will be payable by ITT to Metropolitan as part of ITT's regular monthly payment for the month following notification to ITT from Metropolitan of the amount so payable. If the amount of (2) as specified herein exceeds the amount of (1) as specified herein, then such excess will thereupon be payable to ITT by Metropolitan.

D. For any Experience Period, Metropolitan shall have the right to change the formula for the computation of the service fee, as specified in paragraph A of this Article, by giving written notice of that change to

ITT. For any Experience Period, Metropolitan shall also have the right to change the charge(s) for service(s) not covered by such formula, if any as specified in paragraph A of this Article, by giving written notice of such change(s) to ITT. The right to change such formula and/or charge(s) may be exercised only once with respect to each Experience Period with respect to such formula and each such charge except as specified in paragraph E of this Article. Any such change shall become effective on the date the applicable Experience Period begins or on the date sixty (60) days following the date that written notice is given, whichever date is later. If such change is effective after the date the applicable Experience Period begins, it shall not apply to the portion of the Experience Period which occurred prior to the effective date.

E. The amount of the estimated monthly fee payable during any Experience Period shall be adjusted as deemed appropriate by Metropolitan in the event of a change by 10% or more in the number of employees covered under the Plan or in the event of any change in the Plan which may have an appreciable effect on the amount of benefits payable thereunder.

Article IV. General Provisions

A. During the term of this Agreement, ITT will provide Metropolitan with the statistical information necessary for the administration of the Plan in accordance with the provisions of this Agreement. This information will be provided in such form and at such intervals as are acceptable to ITT and Metropolitan.

B. This Agreement shall be governed by, and shall be construed in accordance with, the law of the State of New York, except as such law is superseded by any provision of ERISA.

C. Metropolitan shall maintain records covering Claims submitted under the Plan, as well as payments disbursed by Metropolitan. The records, the property of

ITT, shall be maintained for the same period of time that Metropolitan retains similar records in connection with its insurance business. Any duly authorized representative or representatives of ITT or the Committee shall have the right to examine or audit such records during the regular business hours of Metropolitan at any time. Upon termination of this Agreement, Metropolitan will be required to surrender such records to ITT, or to an agent selected by ITT, upon receipt by Metropolitan of a customary indemnification from ITT and/or the Agent of ITT with respect to the transfer of such records.

D. In the event Metropolitan pays any person less than the amount to which he or she is entitled under the Plan, Metropolitan will promptly adjust the underpayment.

E. In the event Metropolitan overpays any person entitled to benefits under the Plan or pays benefits to any person who is not entitled to such benefits, Metropolitan will make a reasonable effort to recover the overpayment, but will not be required to initiate court proceedings. Metropolitan will notify ITT if it is unsuccessful in recovering such overpayments. Notwithstanding the foregoing, Metropolitan will not be liable for any overpayment or for any loss incurred by ITT (or the Committee) unless it is the direct result of grossly negligent, dishonest, fraudulent or criminal acts on the part of Metropolitan or any of its directors, officers, or employees or any person directly engaged or retained by Metropolitan to discharge its obligations under this Agreement. In the event Metropolitan and ITT cannot agree as to the nature of the conduct involving the matter under consideration, the question regarding the nature of such conduct shall be settled by arbitration in accordance with the Rules of the American Arbitration Association. In the event Metropolitan reimburses ITT (or the Committee) for an overpayment, Metropolitan shall be subrogated to all rights of ITT (or the Committee, as the case may be,) with respect to

recovery of the overpayment from any person so overpaid and ITT (or the Committee, as the case may be,) will provide reasonable cooperation to Metropolitan in connection with the recovery of the overpayment.

Metropolitan's sources, obligations and responsibilities under this Agreement are extended only to ITT, and, to the extent set forth in this Agreement, to the Committee. Metropolitan assumes no obligations or responsibilities and extends no covenants, direct or indirect, expressed or implied, to any participants in the Plan or to any other person, except for any obligations it may have under ERISA.

F. 1. It is mutually recognized that Metropolitan, in performing its obligations under this Agreement, is acting only as agent of ITT and shall not be designated or deemed the administrator with respect to the Plan for the purposes of ERISA or any other Federal or state law or regulation of similar nature with the exception of its duties as the appropriate named fiduciary for review of claim denials under the Plan.

2. In the event Metropolitan, its officers, directors, employees or agents are made parties to any judicial or administrative proceeding arising in whole or in part out of any function performed by one or more of them under this Agreement, ITT and the Plan shall hold them harmless from and against the payment of all judgments, awards, settlements and reasonable costs (including attorneys' fees) which they incur or pay in connection therewith, except that ITT and the Plan shall not reimburse for the amount of any judgment or award (or attorneys' fees with respect thereto) if the court rendering the judgment or the agency making the award determines that the liability underlying the judgment or award was caused by the gross negligence,

fraud or criminal conduct of Metropolitan, its agents, employees, officers, or directors.

3. In the case of a legal action instituted by any person solely on a claim for benefits under the plan, Metropolitan shall, on behalf of ITT, retain counsel for the defense of such action, employing the same standards for selection of such counsel and the conduct of such litigation as are employed by Metropolitan in the conduct of its insurance business. Metropolitan shall notify ITT of the institution of any such action, including the name of retained counsel, and shall provide quarterly reports on the status of pending action. Invoices reflecting such attorney's fees and other reasonable costs incurred in the defense of such action shall be furnished to ITT no less often than quarterly.

4. In the case of a legal action instituted by any person in whole or in part on a claim other than a claim for benefits, including without limitation a claim based on the fiduciary provisions of ERISA, the defense of such action shall not be an obligation of Metropolitan. Metropolitan shall, however, cooperate with ITT by notifying ITT of the institution of any such action and by furnishing such evidence as it or any subsidiary, affiliate or agent has available in connection with the defense of any such action, including the testimony of any officer, director or employee of Metropolitan or of any subsidiary, affiliate or agent of Metropolitan.

5. In the event ITT, the Plan, the Committee and their respective officers, directors, employees or agents (the "ITT Indemnities") are made parties to any judicial or administrative proceeding arising in whole or in part out of any function performed by Metropolitan or one or more of its officers, directors, employees or agents under this Agreement, Metropolitan shall hold the ITT

Indemnities harmless from and against, payment of all judgments, awarded settlements and reasonable costs (including attorneys' fees), except the payment of Plan benefits, which they incur or pay in connection therewith, if the court rendering the judgment or the agency making the award determines that the liability underlying the judgment or award was caused by the gross negligence, fraud or criminal conduct of Metropolitan, its agents, employees, officers or directors.

6. Subject to the provisions of subparagraphs (2) and (5) of this Section, attorney's fees and other costs incurred in connection with litigation under subparagraphs (3) or (4) of this Section shall be the obligation of and payable by the Trust and/or the Plan, in accordance with the respective terms thereof, subject to ITT's obligation under the Trust to pay such fees and costs in the event the assets of the Trust are not sufficient to make such payments.

G. This Agreement shall be in effect during the first Experience Period and during succeeding Experience Periods, unless ITT or Metropolitan gives written notice to the other, at least thirty (30) days prior to the end of any such Experience Period, that this Agreement is to be terminated at the end of that period. The first Experience Period under this Agreement is the period beginning February 1, 1986 and ending December 31, 1986 and any succeeding Experience Period will begin on January 1st of a calendar year and end on December 31st of that calendar year, provided, that in no event will an Experience Period continue beyond the date of termination of this Agreement as specified in paragraph I of this Article.

H. This Agreement constitutes the entire contract between the parties hereto and no modification or amendment of this Agreement shall be valid unless made in writing and signed by the parties hereto.

I. 1. This Agreement shall terminate on the earliest of:

(a) the date specified with respect to which there has been written notice of termination as provided in paragraph G of this Article;

(b) the last day of the calendar month for which the estimated monthly fee pursuant to paragraph B of Article III is not paid when due as specified therein, unless Metropolitan gives thirty (30) days written notice to ITT that this Agreement will terminate on a later date determined by Metropolitan; and

(c) any other date determined by agreement between ITT and Metropolitan.

2. In the event of termination of this Agreement, Metropolitan will, unless ITT and Metropolitan otherwise agree:

(a) complete the processing of all claims for benefits payable under the Plan that are submitted to and received by Metropolitan prior to the termination; and

(b) at the request of ITT, and at ITT's expense, release to ITT or such other entity as is designated by ITT all records and files relating to claims paid pursuant to this Agreement.

3. If Metropolitan performs any services pursuant to this Agreement following its termination, Metropolitan will be entitled to the fees or other charges on the same basis as if this Agreement had continued in effect until those services were performed.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in duplicate by their respective officers duly authorized to do so, to take effect as of February 1, 1986.

Dated at New York this 23rd day of October 1986

ITT CORPORATION

By /s/ Troy R Goldberg

Dated at Hauppauge this fifth day of November 1986

METROPOLITAN LIFE INSURANCE COMPANY

By /s/ L P Danwan

Dated at New York this 23rd day of October 1986

MEMBER, ITT EMPLOYEE BENEFIT TRUST ADMINISTRATION COMMITTEE

By /s/ Robert W. Broklen

SUPREME COURT RULES RE JURISDICTION ON WRIT OF CERTIORARI, RULE 10 (a), (c) and RULE 13.1

Rule 10. Considerations Governing Review on Writ of Certiorari

.1. A review on writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of certiorari wil be granted only when there are special and important reasons therefor. The following, while neither controlling nor fully measuring the Court's discretion, indicate the character of reasons that will be considered.

(a) When a United States court of appeals has rendered a decision in conflict with the decision of another United States Court of Appeals on the same matter; or has decided a federal question in a way in conflict with a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's power of supervision.

* * *

(c) When a state court or a United States court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.

Rule 13. Review on Certiorari; Time for Petitioning

.1. A petition for a writ of certiorari to review a judgment in any case, civil or criminal, entered by a state court of last resort, a United States court of appeals, or the United States Court of Military Appeals shall be deemed in time when it is filed with the Clerk of this

Court within 90 days after the entry of the judgment. A petition for a writ of certiorari seeking review of a judgment of a lower state court, which is subject to discretionary review by the state court of last resort shall be deemed in time when it is filed with the Clerk within 90 days after the entry of the order denying discretionary review.

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28 U.S.C. § 2101. Supreme Court; time for appeal or certiorari; docketing; stay

(c) Any other appeal or any writ of certiorari intended to bring any judgment or decree in a civil action, suit or proceeding before the Supreme Court for review shall be taken or applied for within ninety days after the entry of such judgment or decree. A justice of the Supreme Court, for good cause shown, may extend the time for applying for a writ of certiorari for a period not exceeding sixty days.

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29 C.F.R. § 2520.102-3 Contents of summary plan description. – Section 102 of the Act specifies information that must be included in the summary plan description. The summary plan description must accurately reflect the contents of the plans as of a date not earlier than 120 days prior to the date such summary plan description is disclosed. The following information shall be included in the

summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in subsection (j) through (n):

(a) The name of the plan, and, if different, the name by which the plan is commonly known by its participants and beneficiaries;

(b) The name and address of –

(1) In the case of a single employer plan, the employer whose employees are covered by the plan,

(2) In the case of a plan maintained by an employee organization for its members, the employee organization that maintains the plan.

(3) In the case of a collectively-bargained plan established or maintained by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, parent, or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as:

(i) A statement that a complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b-1 and 2520.104b-30, or,

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if

t[illegible]mployer or employee organization is a plan sponsor, th[illegible]sponsor's address.

(4) In the case of a plan established or maintained by two or more employers, the association, committee, joint board of trustees, parent, or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as:

(i) A statement that a complete list of the employers sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b-1 and 2520.104b-30, or,

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address. [Amended by 42 FR 37178, effective July 19, 1977.]

(c) The employer identification number (EIN) assigned by the Internal Revenue Service to the plan sponsor and the plan number assigned by the plan sponsor. (For further detailed explanation, see the instructions to the plan description Form EBS-1 and "Identification Numbers Under ERISA" (Publ. [illegible]004), published jointly by DOL, IRS, and PBGC);

(d) The type of pension or welfare plan, *e.g.*, for pension plans – defined benefit, money purchase, profit

sharing, etc., and for welfare plans – hospitalization, disability, pre-paid legal service, etc.;

(e) The type of administration of the plan, *e.g.*, contract administration, insurer administration, etc.;

(f) The name, business address, and business telephone number of the plan administrator as that term is defined by section 3(16) of the Act;

(g) The name of the person designated as agent for service of legal process, and the address at which process may be served on such person, and in addition, a statement that service of legal process maybe made upon a plan trustee or the plan administrator;

(h) The name, title, and address of the principal place of business of each trustee of the plan;

(i) If a plan is maintained pursuant to one or more collective bargaining agreements, a statement that the plan is so maintained, and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§2520.104b-1 and 2520.104b-30. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes;

(j) The plan's requirements respecting eligibility for participation and for benefits. The summary plan description shall describe the plan's provisions relating to eligibility to participate in the plan, such as age or years of

service requirements, and the items listed in subparagraphs (1) or (2) as appropriate:

(1) For employee pension benefit plans, it shall also include a statement describing the plan's normal retirement age, as that term is defined in section 3(24) of the Act, and a statement describing any other conditions which must be met before a participant will be eligible to receive benefits. Such plan benefits shall be described or summarized.

(2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits. In the case of a welfare plan providing extensive schedules of benefits (a medical care plan, for example), only a general description is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests;

(k) In the case of an employee pension benefit plan, a statement describing any joint and survivor benefits provided under the plan, including any requirement that an election be made as a condition to select or reject the joint and survivor annuity;

(l) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by (j) and (k) above.

* * *

ERISA Act Sec. 503. In accordance with regulations of the Secretary, every employee benefit plan shall –

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

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29 U.S.C. § 1001 Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal Taxing power

The Congress finds that the growth in size scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee

organizations, and other entities by which they are established or maintained; that a large volume of activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance. (Pub.L. 93-406, Title I, § 2, Sept. 2, 1974, 88 Stat. 832.)

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29 U.S.C. § 1022. Plan description and summary plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information

described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(2) A plan description (containing the information required by subsection (b) of this section) of any employee benefit plan shall be prepared on forms prescribed by the Secretary, and shall be filed with the Secretary as required by section 1024(a)(1) of this title. Any material modification in the terms of the plan and any change in the information described in subsection (b) of this section shall be filed in accordance with section 1024(a)(1)(D) of this title.

(b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of

the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

---

29 U.S.C. § 1132(a)(e)(g). Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the

terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

* * *

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

* * *

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan –

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of –

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

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29 U.S.C. § 1105(a)(c). Liability for breach of co-fiduciary

(a) Circumstances giving rise to liability

In addition to any liability which he may have under any other provision of this part, a fiduciary with respect

to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances:

> (1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach;
>
> (2) if, by his failure to comply with section 1104(a)(1) of this title in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or
>
> (3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

* * *

(c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities

(1) The instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan.

(2) If a plan expressly provides for a procedure described in paragraph (1), and pursuant to such procedure any fiduciary responsibility of a named fiduciary is allocated to any person, or a person is designated to carry out any such responsibility, then such named fiduciary shall not be liable for an act or omission of such

person in carrying out such responsibility except to the extent that –

(A) the named fiduciary violated section 1104(a)(1) of this title –

(i) with respect to such allocation or designation.

(ii) with respect to the establishment or implementation of the procedure under paragraph (1), or

(iii) in continuing the allocation or designation; or

(B) the named fiduciary would otherwise be liable in accordance with subsection (a) of this section.

(3) For purposes of this subsection, the term "trustee responsibility" means any responsibility provided in the plan's trust instrument (if any) to manage or control the assets of the plan, other than a power under the trust instrument of a named fiduciary to appoint an investment manager in accordance with section 1102(c)(3) of this title.

* * *

H.R. Rep No. 93-533, reprinted in 1974 U.S. Code Cong & Admin. News 4639 (House Report), 4655.

The Committee on Education and Labor, to whom was referred the bill (H.R. 2) to revise the Welfare and Pension Plans disclosure Act, having considered the same, report favorably thereon with an amendment and recommend

that the bill, as amended, do pass. The amendment substitutes all after the enacting clause and inserts a substitute text which appears in italic type in the report bill.

I. Synopsis

The Employee Benefit Security Act as reported by the Committee is designed to remedy certain defects in the private retirement system which limit the effectiveness of the system in providing retirement income security. The primary purpose of the bill is the protection of individual pension rights, but the committee has been constrained to recognize the voluntary nature of private retirement plans. The relative improvements required by this Act have been weighed against the additional burdens to be placed on the system. While modest cost increases are to be anticipated when the Act becomes effective, the adverse impact of these increases have been minimized. Additionally, all . . .

* * *

Title V – Enforcement

The enforcement provisions have been designed specifically to provide both the Secretary and participants and beneficiaries with broad remedies for redressing or preventing violations of the Act. The intent of the committee is to provide the full range of legal and equitable remedies available in both state and federal courts and to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities under state law for recovery of benefits due to participants. For actions in federal courts, nationwide service of process is provided in order

to remove a possible procedural obstacle to having all proper parties before the court.

Except where plans are not subject to this Act and in certain other enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards, for evaluation of fiduciary conduct, and for creating a single reporting and disclosure system in lieu of burdensome multiple reports. As indicated previously, however, the Act expressly authorizes cooperative arrangements with state agencies as well as other federal agencies, and provides that state laws regulating banking, insurance or securities remain unimpaired.

The Act makes it unlawful for any person to discharge, fine, suspend, expel, discipline or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of the plan or the Act, or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan or the Act.

The Act makes it a criminal offense for any person to use fraud, force, or violence or threats thereof to restrain, coerce, intimidate or attempt to restrain, coerce, intimidate any participant or beneficiary for the purpose of interfering with or preventing the exercise of any right to which he is or may become entitled under the plan, or the Act.

Although the instances of these occurrences are relatively small in number, the committee has concluded that

safeguards are required to preclude this type of abuse from being carried out and in order to completely secure the rights and expectations brought into being by this legislation.

VII. Section-by-Section Analysis

PURPOSES

The Employee Benefit Security Act is designed (1) to establish minimum standards of fiduciary conduct for Trustees, Administrators and others dealing with retirement plans, to provide for their enforcement through civil and criminal sanctions, to require adequate public disclosure of the plan's administrative and financial affairs, and (2) to improve the equitable character and soundness of private pension plans by requiring them to: (a) vest the accrued benefits of employees with significant periods of service with an employer, (b) meet minimum standards of funding and (c) guarantee the adequacy of the . . .

(2)

No. 90-961

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

ERVIN B. MADDEN,
Petitioner,
vs.
ITT LONG TERM DISABILITY PLAN FOR SALARIED EMPLOYEES; FEDERAL ELECTRIC CORPORATION,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Should this Court review the question whether, where an ERISA plan expressly gives an administrator or fiduciary discretionary authority to determine eligibility for benefits and authority to delegate such discretionary authority to another fiduciary, and the plan administrator properly delegates such discretionary authority to another fiduciary, the arbitrary and capricious standard of review applies to such other fiduciary, as well as to the plan administrator, under this Court's decision in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989)?

2. Should this Court review the question whether, where an ERISA plan expressly provides for the reduction of plan benefits by Social Security disability insurance benefits, the plan is entitled to recover the retroactive Social Security benefits the plan participant receives for the period he or she also receives plan benefits?*

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* The parent company of respondent Federal Electric Corporation, which was renamed ITT Federal Services Corporation in July, 1990, is ITT Corporation, a publicly held company. All of Federal Electric Corporation's subsidiaries are wholly owned.

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No. 90-961

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1990

ERVIN B. MADDEN,
Petitioner,
vs.
ITT LONG TERM DISABILITY PLAN FOR SALARIED EMPLOYEES; FEDERAL ELECTRIC CORPORATION,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondents, the ITT Long Term Disability Plan For Salaried Employees (the "Plan") and Federal Electric Corporation, respectfully request that this Court deny the Petition for Writ of Certiorari seeking review of the Ninth Circuit's decision in this case. That decision is reported at 914 F.2d 1279 (9th Cir. 1990).

STATEMENT OF THE CASE

Respondents do not deem it necessary to set forth detailed corrections to petitioner's Statement of the Case. Rather, for purposes of this Brief in Opposition,

respondents simply rely on the Court of Appeals' statement of the case, *see* 914 F.2d at 1281-1285, and the following brief statement.

1. The Plan Administrator's Discretionary Authority And The Delegation Of That Authority To Metropolitan

The Plan expressly provides ITT Corporation ("ITT"), which is the plan sponsor and the plan administrator, with discretionary authority to determine eligibility for benefits and to construe the terms of the Plan and, further, that such authority may be delegated to an ERISA claims review fiduciary.

Specifically, the Plan provides that the plan administrator:

> Shall have the exclusive right . . . to interpret the Plan and to decide any and all matters arising hereunder, including the right to remedy possible ambiguities, inequities, inconsistencies or omissions . . . . [A]ll interpretations of [the plan administrator] . . . with respect to any matter hereunder shall be final, conclusive and binding on all parties affected thereby. [CR 21, pp. 72-73.]

The Plan also expressly provides, as permitted by ERISA in 29 U.S.C. §§ 1102(a)(2) and 1105(c)(1), that the plan administrator may designate another person as named fiduciary for the full and fair review of claims:

> The [plan administrator] may delegate its authority with respect to the denial,

> granting and administration of claims to a Claims Administrator which may be an insurance company or other appropriate named fiduciary and may enter into a claims administration agreement with such Claims Administrator for the handling and determination of claims, including, but not limited to, the granting or denial of claims and any appeals therefrom. [C.R. 21, pp. 71-72.]

Based on this express authority, ITT, the plan administrator, designated Metropolitan Life Insurance Company ("Metropolitan") as ERISA claims review fiduciary pursuant to a Claims Administration Agreement:

> Upon receipt of a claim, Metropolitan shall review the claim including evaluation by Metropolitan's consultants when required, and determine whether it has been properly filed and the amount, if any, which is due and payable with respect thereto. In making benefit payments, Metropolitan will determine the validity of each claim presented and will, as necessary, make appropriate investigations within the time prescribed for processing claims pursuant to Section 503 of ERISA [(29 U.S.C. § 1133)] . . .
>
> * * *
>
> If benefits are to be wholly or partially denied, Metropolitan shall notify the claimant within a

> reasonable period of time .... Metropolitan will have fiduciary responsibility for provision of full and fair review of claim denials pursuant to Section 503 of ERISA [(29 U.S.C. § 1133)]. Final determination of payment or denial of appealed claims will be made following appropriate analysis and review. [The plan administrator] will promptly submit to Metropolitan any request it receives for a review of a claim for benefits which has been denied, in order that Metropolitan may provide a full and fair review of the claim. [CR 21, p. 93 (Appendix to Petition, pp. 51-52).]

ITT, as the plan administrator, did, however, retain ultimate discretion to construe the terms of the Plan:

> [I]n the event that ITT determines that Metropolitan has misinterpreted the Plan and so informs Metropolitan in writing of such appropriate interpretation, and such interpretation is deemed not unreasonable and not inconsistent with the terms of the Plan to Metropolitan, all claims processed after delivery of such writing to Metropolitan shall be in accordance with the interpretation of ITT, set forth in such writing. [CR 21, pp. 95-96 (Appendix to Petition, p. 53).]

Thus, (1) the Plan expressly gives ITT, the plan administrator, discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, (2) the Plan expressly permits delegation of that

authority to an insurance company as named fiduciary, (3) the delegatee of such authority is to be a named fiduciary with respect to the full and fair review of claims and appeals, (4) the plan administrator in fact delegated such authority to Metropolitan, and (5) Metropolitan served as ERISA claims review fiduciary for the Plan. All of these procedures are authorized by ERISA, which contains detailed provisions allowing for the delegation of fiduciary responsibility to a party who, pursuant to a procedure specified in the plan, then becomes a named fiduciary. *See* 29 U.S.C. §§ 1102(a)(2), 1105(c)(1), 1133.

2. Petitioner's Claim For Plan Benefits And Metropolitan's Review Of His Claim

Petitioner sustained a back injury in 1983, and it is undisputed that he remained totally disabled pursuant to the terms of the Plan and, accordingly, entitled to Plan benefits until 1985. [CR 21, pp. 30-33.] Then, in August 1985, petitioner's attending physician, Dr. Edward A. Smith, upgraded petitioner's condition. Dr. Smith stated that while petitioner was totally disabled from his own job, he was not totally disabled from any other occupation, the Plan's standard of disability in effect at that time. [CR 21, pp. 32-34, 245, 261-262.] Upon review of Dr. Smith's findings and analysis of petitioner's training, education and experience, Metropolitan determined that petitioner no longer qualified for Plan benefits. [CR 21, pp. 34, 232.]

Petitioner then requested a review of Metropolitan's decision. [CR 21, pp. 34, 223-225.] As part of its review, Metropolitan requested petitioner to provide it

with any additional medical information which might aid in review of his claim. [CR 21, pp. 34-35, p. 222.] After four such requests, Metropolitan received detailed information from Dr. Smith confirming his earlier finding of "no total disability" and opining that petitioner had no physical limitations on certain physical activities such as operating electrical equipment, concentrated visual activities, grasping, handling and finger dexterity, activities important in petitioner's occupation in the electronics field.[1] [CR 21, pp. 35-36, 219-221, 332.]

Pursuant to its duties as ERISA claims review fiduciary, Metropolitan reviewed its original decision to terminate Plan benefits. Based on Dr. Smith's findings, Metropolitan affirmed its decision and again invited petitioner to provide it with additional medical information. [CR 21, pp. 36, 216.]

Again, no such information was forthcoming. Instead, petitioner filed a complaint with the State of Washington Department of Insurance. Pursuant to the complaint, Metropolitan conducted a second review of its original decision, again affirming the decision to terminate benefits. [CR 21, pp. 37, 181, 199-201.]

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[1] Petitioner's claim, at page 4, footnote 3 of the Petition, that "[t]he Ninth Circuit's third footnote indicates there was no evidence in the record pertaining to Dr. Jean Michaels' orthopedic evaluation requested by the Social Security Administration" is false. In fact, in that footnote the Ninth Circuit indicated that there was no evidence in the record that Dr. Michaels' evaluation, as well as other medical reports petitioner claims support his claim, was ever forwarded to Metropolitan. Rather, the only medical reports before Metropolitan when it made its decision and reviewed, and re-reviewed and re-re-reviewed that decision, were those of petitioner's attending physician, Dr. Smith. In any event, the "other" reports contain outdated medical information from 1983, 1984 and early 1985, when petitioner admittedly was totally disabled, and, accordingly, are irrelevant.

Petitioner then requested a *third* review of his claim, again providing no additional medical evidence to controvert his attending physician's opinion. Despite the fact that no new evidence was presented, Metropolitan conducted yet a third review, this time utilizing the services of an independent vocational assessment agency. Not surprisingly, in light of the medical evidence, the agency agreed with petitioner's physician and with Metropolitan that petitioner did not meet the Plan's standard of total disability. Metropolitan, therefore, upheld its decision to terminate Plan benefits and petitioner brought this lawsuit. [CR 21, pp. 38, 39, 166, 173, 176-178.]

Importantly, after reviewing the evidence, including the medical evidence which petitioner alleges supports his claim but which evidence he never forwarded to Metropolitan, the District Court held that Metropolitan's decision to terminate Plan benefits to petitioner was correct and must be upheld not only under an arbitrary and capricious standard of review, but even under a *de novo* standard of review. [CR 33, p. 8 (Appendix to Petition, p. 31).]

REASONS WHY THE PETITION SHOULD BE DENIED

The Petition for Writ of Certiorari should be denied.

Although petitioner claims that there is a conflict among the circuits with respect to the first question, in actuality, no conflict exists. Rather, the alleged conflict stems from petitioner's misperception of the undisputed facts in this case. Unlike the facts in the cases petitioner relies on to support the alleged conflict, in this case the Plan at issue expressly provided that ITT, the plan administrator, had discretionary authority to determine

eligibility for benefits and had authority to delegate such discretionary authority to an insurance company to serve as ERISA claims review fiduciary. Further, in this case, the requisite discretionary authority was in fact properly delegated to an insurance company and the insurance company in fact served as the Plan's claims review fiduciary.

Moreover, the Ninth Circuit's decision with respect to the first question was correct and consistent with this Court's holding in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989) and with ERISA's own provisions which permit a plan to have a procedure under which discretionary authority is delegated to another party, who then becomes a named fiduciary. It makes no sense to permit a plan fiduciary to delegate authority where necessary, but to penalize the plan for such delegation by imposing a more stringent standard of review when it does so.

The second question presented by the Petition not only was decided correctly by the Ninth Circuit, but is not a question of significance worthy of review by this Court because it turns on the specific facts presented by this case. Although this question is important to the parties, there is no public importance associated with its outcome.

I.

THE FIRST QUESTION IS NOT A SOURCE OF CONFLICT AMONG THE CIRCUITS.

The first question presented by the Petition is whether an insurance company's decisions are to be reviewed under an arbitrary and capricious standard of review where the employee benefit plan at issue expressly gives the plan administrator discretionary authority to determine eligibility for benefits and to delegate such authority to another fiduciary, the plan administrator does delegate such authority, and the insurance company, pursuant to such delegation, serves as ERISA claims review fiduciary. Following this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Ninth Circuit held that the arbitrary and capricious standard does apply in these circumstances. Apart from noting the obvious correctness of the Ninth Circuit's resolution of this question, discussed in Part II, hereof, it is respectfully submitted that there is no conflict among the circuits on this issue.

The alleged conflict raised in the Petition allegedly stems from two cases decided by the Eleventh Circuit, *Baker v. Big Star Division of Grand Union Co.*, 893 F.2d 288 (11th Cir. 1989) and *Moon v. American Home Assurance Co.*, 888 F.2d 86 (11th Cir. 1989), and one case decided by a district court, *Buchholz v. General Electric Employee Benefit Plan*, 720 F. Supp. 102 (N.D. Ill. 1989). Petitioner's reliance on these cases as creating a conflict among the circuits, however, is misplaced.

In claiming a conflict among the circuits, petitioner relies on language from these three cases to the effect that where the purely administrative function of initial

claims processing (as distinguished from ERISA's procedure for *review* of claims denials by a named fiduciary, 29 U.S.C. § 1133) has been delegated to an insurance company, the insurance company is not a fiduciary, and, accordingly, its decisions are not subject to the arbitrary and capricious standard of review. *See* Petition at pp. 13-17. Thus, according to petitioner, since Metropolitan allegedly did not serve as claims review fiduciary, the Ninth Circuit's decision is in conflict with the *Baker, Moon,* and *Buchholz* decisions. This conclusion is wrong; an analysis of the undisputed facts reveals that there is no conflict.

First, unlike the instant case, *Baker, Moon,* and *Buchholz* do not involve plans where the plan administrator not only expressly is given discretionary authority to determine eligibility for benefits but also expressly is given authority to delegate that authority to another fiduciary. *See Baker v. Big Star Division of Grand Union Co., supra,* 893 F.2d at 290-92 (court rejected argument that plan fiduciary had "inherent discretionary authority" and, accordingly, that it had "inherent" power to delegate that authority to an insurance company to process claims); *Moon v. American Home Assurance Co., supra,* 888 F.2d at 88-89 (no express grant of discretionary authority to plan administrator and, hence, to insurance company which processed claims); *Buchholz v. General Electric Employee Benefit Plan, supra,* 720 F. Supp. at 103-105 (no discretionary authority to determine eligibility for benefits provided by terms of plan).

Second, both the District Court and the Ninth Circuit found that Metropolitan served as ERISA claims review fiduciary.[2] Moreover, an analysis of the relevant facts

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[2] Because both the District Court and the Court of Appeals found that Metropolitan served as claims review fiduciary, application of

(continued)

indicates that the Courts' determination of this factual issue was correct.

ERISA defines a "fiduciary" as one who

> exercises any discretionary authority or discretionary control respecting management of [a] plan or exercises any authority or control respecting management or disposition of its assets . . . or has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A)(i). Pursuant to ERISA, a claims review fiduciary shall afford "a full and fair review" of any decision denying a claim for benefits. 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(g)(1) (employee benefit plans must establish procedures by which denied claims may be appealed to "an appropriate named fiduciary . . . and under which a full and fair review of the claim and its denial may be obtained"). Moreover, under ERISA, a named fiduciary may delegate its fiduciary responsibilities to other persons:

> The instrument under which a plan is maintained may expressly provide for procedures . . . (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than

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(ftn. continued)
the "two court rule" precludes review by this Court "in the absence of a very obvious and exceptional showing of error." *Graver Tank & Mfg. Co. v. Linde Air Products Co.*, 336 U.S. 271, 275 (1949). Petitioner has made no such showing here.

> trustee responsibilities) under the plan.

29 U.S.C. § 1105(c)(1); *see also* 29 U.S.C. § 1102(a)(2).

Here, as noted above, ITT, the plan administrator, not only is given the discretionary authority to construe the terms of the Plan and determine eligibility for benefits, but also is given the express authority to *delegate* that authority. Pursuant to such authority, ITT delegated to Metropolitan its discretionary authority to determine eligibility for benefits and review denied claims. Metropolitan, in turn, agreed to provide the full and fair review of claims and to serve as ERISA claims review fiduciary and, in fact, did so.

Although petitioner claims that ITT did no more than "rent" Metropolitan's claim department and, accordingly, that Metropolitan did not serve as a fiduciary, *see* Petition at pp. 11, 20-23, this contention is belied by the undisputed facts.

Unlike the case in the *Baker, Moon,* and *Buchholz* cases relied on by petitioner, Metropolitan did more than perform the initial determination of petitioner's claim. Rather, pursuant to its express grant of authority, upon petitioner's appeal of its decision terminating payment of Plan benefits, Metropolitan, acting in its capacity as ERISA claims review fiduciary, reviewed, re-reviewed and re-re-reviewed its initial decision. And, in performing its review, Metropolitan had the full discretion to determine petitioner's claim. Thus, unlike the insurance company/claims administrators in *Baker, Moon,* and *Buchholz,* Metropolitan served as ERISA claims review fiduciary.

Accordingly, the perceived conflict among the circuits is an illusory one based upon petitioner's misperception of the undisputed facts.

II.

THE NINTH CIRCUIT'S RULING ON THE FIRST QUESTION IS CORRECT AND IS CONSISTENT WITH THIS COURT'S DECISION IN *FIRESTONE TIRE & RUBBER CO. v. BRUCH* AND THE PROVISIONS OF ERISA.

Even assuming, for the sake of argument, that in fact there is a conflict among the circuits on the first question — and, as discussed above, there is not — the Ninth Circuit's decision on the first question was correct and consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch, supra,* and the provisions of ERISA.

In *Firestone* this Court ruled that

> a denial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.

Firestone Tire & Rubber Co. v. Bruch, supra, 489 U.S. at 115.

Here, as discussed above, under the terms of the Plan, ITT, which served as plan administrator, was given, and in turn delegated to Metropolitan, discretionary authority "to determine eligibility for benefits or to construe the terms of the plan." It would thwart the clear intent of Congress and make no sense to hold that where a plan

administrator is given the requisite discretionary authority pursuant to *Firestone* and is also given by the plan the power to delegate such discretionary authority to another fiduciary, pursuant to statute, *see* 29 U.S.C. §§ 1105(c)(1), 1102(a)(2), and 1133, that one standard of review, the arbitrary and capricious standard, applies to the plan administrator but another standard of review, the *de novo* standard, applies to the insurance company/ claims review fiduciary to which such discretionary authority is delegated.

If plan decisions were to be accorded a greater or lesser degree of deference depending on whether plan fiduciaries delegated their authority to other persons, this would have the effect of discouraging delegation of authority to experts where such delegation is proper. Congress, in providing in ERISA for procedures for the delegation of fiduciary duties, plainly encouraged the use of experts. Indeed, it is submitted that it may be a breach of a fiduciary's responsibility *not* to delegate the requisite authority in specialized areas, such as disability claims reviews, where the fiduciary does not possess the requisite expertise to fulfill its responsibility to the plan and to plan participants and beneficiaries.

There simply is no logical reason why, where the plan administrator/named fiduciary is expressly given discretionary authority and properly delegates that discretionary authority to another fiduciary, the named fiduciary to which the authority is delegated should not be accorded the same degree of deference in its decision making as is the plan administrator/named fiduciary. The Ninth Circuit's decision, therefore, is correct and is consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch, supra,* as well as the provisions of ERISA.

III.

THE SECOND QUESTION DOES NOT PRESENT AN ISSUE OF GENERAL IMPORTANCE.

The second question presented by the Petition is whether, where an ERISA plan provides for the reduction of plan benefits by Social Security disability insurance benefits, the plan is entitled to recover the retroactive Social Security benefits the plan participant receives for the period he or she also receives plan benefits.[3]

This question is not of sufficient importance to warrant review by this Court under Supreme Court Rule 10(c). Rather, this issue is fact specific, involving a construction of the terms of the Plan as reflected by the summary plan description. Both the District Court and the Ninth Circuit found that the Plan provides for a reduction of Plan benefits by the amount of Social Security disability insurance benefits paid to a Plan participant and that this reduction is clearly set forth in the summary plan description. Petitioner, however, in effect claims that because the Social Security Administration incorrectly denied his claim for benefits at first, only later reversing itself and awarding retroactive benefits *after* the Plan had begun paying Plan benefits to him, that he therefore is entitled to keep the retroactive Social Security benefits.

This claim defies logic. The Plan clearly provides, and petitioner admits, that payable Plan benefits are to be reduced by Social Security benefits. No limitation is

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[3] Petitioner's assertion that the Plan filed its Counterclaim seeking reimbursement of the retroactive Social Security benefits only after it filed its motion for summary judgment is wrong.

placed on the time at which the Social Security benefits are paid. Rather, the terms of the Plan require a reduction of Plan benefits for Social Security benefits payable for the same period regardless of when the Social Security benefits are actually paid. Were petitioner permitted to keep the Social Security benefits, the terms of the Plan would be violated and petitioner would be unjustly enriched, at the expense of the Plan and other Plan participants, due solely to the Social Security Administration's delay in awarding benefits. Petitioner would receive a windfall at the expense of the other Plan participants. Thus, not surprisingly, petitioner's argument was rejected by the Ninth Circuit, and other courts which have faced this issue have rejected similar arguments. *See Stuart v. Metropolitan Life Ins. Co.*, 664 F. Supp. 619 (D. Me. 1987), *aff'd*, 849 F.2d 1534 (1st Cir.), *cert. denied*, 488 U.S. 968 (1988); *Poisson v. Allstate Life Ins. Co.*, 640 F. Supp. 147 (D. Me. 1986); *Barklage v. Metropolitan Life Ins. Co.*, 614 F. Supp. 51 (W.D. Mo. 1985); *Henning v. Metropolitan Life Ins. Co.*, 546 F. Supp. 442 (M.D. Pa. 1982).

CONCLUSION

The Petition for Writ of Certiorari in this case presents questions which are of limited significance because they were resolved against petitioner by both courts below based upon the particular facts of the case. When these facts are analyzed, it is clear that there is no split among the circuits on the first question and that this question was correctly decided by the Ninth Circuit on the facts of this case, and that the second question similarly depends solely on the applicable facts. For these reasons, the Petition should be denied.

Respectfully submitted,

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APPENDIX A

STATUTES, REGULATIONS AND RULES

29 U.S.C. § 1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly . . . .

29 U.S.C. § 1105. Liability for breach of co-fiduciary

* * *

(c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities

(1) The instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan . . .

29 U.S.C. § 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall —

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 C.F.R. § 2560.503-1 Claims procedure . . .

(g) *Review procedure.* (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

Supreme Court Rule 10. Considerations Governing Review on Writ of Certiorari

.1 A review on writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of certiorari will be granted only when there are special and important reasons therefor. The following, while neither controlling nor fully measuring the Court's discretion, indicate the character of reasons that will be considered:

. . .

(c) When a state court or a United States court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.